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ABSTRACT

In 1990, Project CHERISH (Children in Home Environments: Regulation to Increase Safety and Health) enabled the Texas Department of Human Services to implement and evaluate several innovative strategies to strengthen regulation of family day care homes. This report contains descriptions of those strategies, an evaluation of their efficacy, and other information useful for improving the regulation of such homes. The introductory section offers background on the regulation of family day care homes and discusses the objectives of Project CHERISH. The second section gives an overview of the methodology employed in the project and the third section presents a summary of data collected on facilities, children, and caregivers. Findings on compliance with minimum standards and an analysis of minimum standards are presented in the fourth and fifth sections, respectively. The sixth section discusses the monitoring process used in the project, and section seven describes the public information campaign undertaken as part of the project. The last section presents the summary and recommendations of Project CHERISH. Appendixes included with the report are: (1) Minimum Standards for Registered Family Homes; (2) Guidelines To Determine Appropriateness of Monitoring Visit; (3) Instructions for Choosing Homes To Visit from the Sampling List; (4) Research Instruments; and (5) Project Staff. (TJQ)

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PROJECT CHERISH
(Children in Home Environments: Regulation to Improve Safety and Health)

FINAL REPORT

January 1992

PS 021344

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Dear Friend:

Since the enactment in 1885 of the first child care regulation law in the country, the states have continually wrestled with the troublesome question of how best to regulate family day care. There is widespread agreement that traditional licensing has been significantly less effective for day home care than for center-based child care.

The 1968 publication Licensing of Child Care Facilities by State Welfare Departments (Children's Bureau publication number 462-1968) suggested registration as a viable alternative.

> "Required registration of certain types of family facilities, plus right of inspection, might result in better protection for the time being than a formal license system suffering from manpower shortages and possibly community resistance to formal license requirements. **(It) would help to establish the magnitude of the problem and thus provide a basis for program planning.**" (Bold added.)

Although approximately half of the states in the country have implemented registration programs for family day homes, none of them has, to our knowledge, assessed their impact. Texas has now done so through its Project CHERISH (Children in Home Environments: Regulation to Increase Safety and Health).

While we recognize that this report is specific to family day care in Texas, we believe many of the findings contained herein could be found in other state child care regulation programs. We are happy to share this report with you. Whether you provide, regulate, or advocate family day home care, we hope you find this report useful in your attempts to increase the safety and health of children.

Sincerely yours,

Cris Ros-Dukler
Director of Licensing

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PROJECT CHERISH
(Children in Home Environments: Regulation to Increase Safety and Health)

Upgrading the Regulatory Program	• Child care in registered family homes (RFHs) has been less regulated than child care in licensed day care facilities.
	• New minimum standards for RFHs in effect July 1990 stress caregiver competencies, requiring:
	  • High school diploma/GED
	  • 20 hours child care related training per year
	  • CPR certificate
	  • First aid certificate
	• Twenty percent monitoring plan for registered family homes begins July 1990.

Objectives of the Program	• Collect useful information about the RFH facility, children, and caregiver, including training needs. • Obtain detailed information about compliance with the minimum standards including perceived obstacles. • Evaluate the minimum standards as a regulatory tool. • Evaluate the monitoring plan. • Develop and implement a state-wide public information campaign to increase parents' involvement in monitoring their day care.

Key Results

- Over 3000 monitoring visits were completed with over 1.5 million pieces of information collected.

- Most facilities have an animal and outdoor play equipment.

- The typical caregiver is younger and more educated than in 1978 and has about 19 hours of child care related training over the past two years.

- An average RFH has 5 children in care. 50% are female, 23% are infants, 59% are preschool age, 18% are school age.

- Twenty one standards accounted for most of the noncompliances. Of 113 standards, the top five least complied with standards account for 35% of the total noncompliances; the top 12, 63%; the top 21, 77%.

- Three of four RFHs have 4 or more noncompliances. Only 5% are in complete compliance compared to 30% in 1978.

- Increased compliance is associated with:

  - membership in child care associations,
  - membership in child referral services,
  - having at least a high school diploma,
  - increased hours of training in child care,
  - attendance at minimum standards training.

- Not understanding the rationale for the standard is the most ubiquitously cited difficulty in compliance.

- Caregivers rated the standards as clear, comprehensive and useful, the visits as helpful and agreeable, the monitors as knowledgeable.

- 1-800 telephone line set up in tandem with public information campaign.

FINDINGS AND RECOMMENDATIONS

THE FACILITY AND CAREGIVER

- A large percentage of playground equipment and swimming pools at RFHs was not evaluated because the provider stated that she did not allow children to use the equipment.
  Recommendation: Evaluate all playground equipment and pools as accessible or require physical safeguards to ensure that unused equipment and pools are at all times inaccessible to children.
- Caregivers vary widely in age, education, professional experience, and location.
  Recommendation: Ensure the content of training delivered by TDHS is appropriate to the age, education, and professional experience of caregivers. Develop alternate methods of delivering training so that training is accessible to all caregivers.
- Child development and business management are training areas that caregivers have taken the least and request the most.
  Recommendation: Identify, develop, make available, and encourage training opportunities in these areas.

COMPLIANCE WITH MINIMUM STANDARDS

- Involvement in professional activities such as child care associations is related to lower levels of noncompliance.
  Recommendation: Continue to encourage and support membership and participation in child care associations and other professional activities.
- Caregivers want to comply with the minimum standards and provide good care for children.
  Recommendation: During monitoring visit work with provider to identify strengths and weaknesses and develop a personal training plan.

MINIMUM STANDARDS

- Providers understand the minimum standards but many find it difficult to translate this understanding into methods for achieving compliance with them.
  Recommendation: Provide written rationale for each standard with examples of successful compliance along with the minimum standards during the registration process. Use the orientation to elaborate and supplement this material.
- Areas of risk not currently in the standards were identified by caregivers and monitors.
  Recommendation: Examine the list for conditions which require immediate regulatory attention and use list during next comprehensive review of the standards.

MONITORING VISITS

- A monitoring visit can reduce the number of noncompliances in the RFH to zero.
  Recommendation: Make monitoring visit a requirement for registration.
- Monitoring visits decrease the average level of noncompliance across the state.
  Recommendation: Develop temporary monitoring plan to evaluate the 21 least complied with standards in the remaining RFH population until every operating RFH has been inspected with either the full or partial evaluation. Then use registration visit to achieve full compliance in new RFHs in combination with a small random sample full evaluation to continuously monitor compliance rates.

PUBLIC INFORMATION CAMPAIGN

- It is expected that the campaign will be successful in raising the public's awareness of child care options, the regulation of day care facilities, and parental responsibility.
  Recommendation: Identify, develop, encourage, and support initiatives to increase and maintain parent involvement in child care issues.

TABLE OF CONTENTS

TABLE OF FIGURES 10

I. INTRODUCTION 12
  A. BACKGROUND 12
  B. FACTORS IN REGULATING FAMILY DAY HOMES 13
    1. Historical Events 13
    2. Unequal facility type/child ratio 13
    3. Partnership Philosophy 14
      Caregivers 14
      Parents 14
  C. THE REGISTRATION PROCESS 14
  D. OBJECTIVES OF PROJECT CHERISH 15
    1. Collect data about the RFH facility, children, and caregiver . . . 15
    2. Obtain information about compliance with the minimum standards 16
    3. Evaluate the minimum standards 16
    4. Evaluate the monitoring plan 18
    5. Implement a state-wide public information campaign to increase parents' motivation to monitor their child care 18

II. METHODOLOGY 19
  A. IDENTIFYING THE SAMPLE 19
  B. MONITORS AND MONITOR TRAINING 20
  C. SURVEY INSTRUMENTS AND DATA 21
    1. Tracking Sheet 22
    2. Cover Sheet 22
    3. Minimum Standards Evaluation Checklist 22
    4. Standard Interview with Caregivers 23
    5. Questionnaire for Project Staff 23
    6. Caregiver Mail-in Questionnaire 24
    7. Travel and salary cost data 24
    8. Data from a previous licensing study 25

III. THE FACILITY, CHILDREN, AND CAREGIVER 26
  A. THE FACILITY 26
    1. Outside 27
    2. Inside 30
    3. Neighborhood 31
  B. THE CAREGIVER 34
    1. Age and sex 34
    2. Education 35
    3. Memberships 36
    4. Familiarity with standards 36
  C. CAREGIVER TRAINING 37
    1. Minimum standards training 37
    2. Community college training 37
    3. Other training 37
  D. PLACE OF TRAINING 38
  E. HOURS OF TRAINING 39
    1. Caregiver characteristics and training hours 39
  F. TRAINING SUGGESTIONS 40
  G. THE CHILDREN 42
  H. QUALITY AND CAREGIVER PRACTICES 43
    1. Snacks and meals provided 43
    2. Rating other aspects of the RFH 43
    3. Four major aspects of RFHs identified 44
    4. Relationship among the four factors 46
    5. Relationship of four factors to other indices 47

IV. COMPLIANCE WITH THE MINIMUM STANDARDS 49
  A. OVERALL COMPLIANCE LEVELS 49
  B. NONCOMPLIANCE RATES FOR EACH STANDARD 50
    1. Standards with over 50% noncompliance 50
    2. Standards with 25% to 49% noncompliance 52
    3. Standards with 15% to 24% noncompliance 53
  C. LOW NONCOMPLIANCE 54
  D. NONCOMPLIANCE BY STANDARDS SECTION 56
  E. FACTORS INCREASING COMPLIANCE WITH THE STANDARDS 59
    1. Level of training 59
    2. Elective activities 60

3. Combinations of training and elective activities 60
4. Predicting noncompliance with level of training and elective activities 62
5. Noncompliance and facility variables 62
6. Predicting noncompliance with facility variables 64
7. Noncompliance and RFH factors 64
8. Predicting noncompliance with four RFH factors 66

F. PERCEIVED DIFFICULTIES IN MEETING THE STANDARDS .. 67
1. Cited difficulties 67
2. General perceptions 70

V. **ANALYSIS OF THE MINIMUM STANDARDS 72**
A. DIMENSIONAL RATINGS OF THE MINIMUM STANDARDS ... 72
1. Specificity 72
2. Time 73
3. Observability of (non)compliance 75
4. Technical consultation 76

B. CORRELATION OF DIMENSIONS 77
C. RATINGS BY CAREGIVERS 78
D. UNIDENTIFIED AREAS OF RISK 80
E. SUMMARY 82

VI. **THE MONITORING PROCESS 83**
A. ATTEMPTED VISITS 83
B. TELEPHONE SCREENING 83
C. RFHs VISITED 85
D. TIME IN RFH 85
E. PREDICTING TIME IN THE RFH 86
F. RECORDING OF MONITORING VISITS 87
G. CAREGIVER REACTIONS 88
H. RECOMMENDED IMPROVEMENTS TO THE MONITORING SYSTEM 89
I. COSTS 90
1. Total cost per visit 90
2. Travel cost per visit 93
3. Budget summary 96

VII. PUBLIC INFORMATION CAMPAIGN 97
- A. IDENTIFYING APPROPRIATE INFORMATION 97
- B. THE MEDIA CAMPAIGN 97
- C. THE 1-800 CHILD CARE HOTLINE 99
- D. OTHER BENEFITS 99

VIII. SUMMARY AND RECOMMENDATIONS 100
- A. THE RFH FACILITY, CHILDREN, AND CAREGIVER 100
  - 1. The facility 100
  - 2. The children in care 102
  - 3. The caregiver 102
- B. COMPLIANCE WITH MINIMUM STANDARDS 103
  - 1. Rates of noncompliance 103
  - 2. Patterns of noncompliance 104
  - 3. Increasing compliance 104
  - 4. Predicting RFHs with high noncompliance 104
  - 5. Problems in complying 105
- D. THE MINIMUM STANDARDS 106
- E. THE MONITORING PROCESS 106
- F. THE PUBLIC INFORMATION CAMPAIGN 107
- G. THE EFFECTS OF MONITORING ON COMPLIANCE 107

APPENDICES
- Appendix A Minimum Standards for Registered Family Homes
- Appendix B Guidelines to Determine Appropriateness of Monitoring Visit
- Appendix C Instructions for Choosing Homes to Visit from the Sampling List
- Appendix D Research Instruments
- Appendix E Project Staff

TABLE OF FIGURES

Figure	Description	Page
1	RFH Environments, Residence and Locale	26
2	Characteristics of RFH, Water Related	27
3	Characteristics of RFH, Play Equipment	28
4	Characteristics of RFH, Animals in the RFH	29
5	Characteristics of RFH, Fire Related	30
6	RFH Environments, Cleanliness of Neighborhood	31
7	RFH Environments, Neighborhood Safety	32
8	RFH Environments, Traffic in Neighborhoods	33
9	Age of Caregivers	34
10	Education of Caregiver	35
11	Caregiver Educational and Network Characteristics	36
12	Number of Children in RFHs	42
13	Percentage of RFHs at Each Level of Noncompliance	49
14	Noncompliance Rates for Major Minimum Standards Sections	56
15	Noncompliance Rates for Minimum Standards Sub-sections	57
16	Problems in Meeting Minimum Standards	67
17	Percent of Providers Citing No Difficulties in Meeting Standards for Each Standards Section	68
18	Number of Standards for Each Level of Observability	75
19	Number of Standards for Each Level of Consultation	77
20	Caregivers' Ratings of Minimum Standards	79
21	Number of RFH Monitoring Visits per Month	85
22	Provider Response to Monitoring Visits	88

23	Total Cost Per Visit By Month	90
24	Total Cost Per Visit By Month for Regional Area I	91
25	Total Cost Per Visit By Month for Regional Area II	91
26	Total Cost Per Visit By Month for Regional Area III	92
27	Total Cost Per Visit By Month for Regional Area IV	92
28	Travel Cost Per Visit By Month	93
29	Travel Cost Per Visit By Month for Regional Area I	94
30	Travel Cost Per Visit By Month for Regional Area II	94
31	Travel Cost Per Visit By Month for Regional Area III	95
32	Travel Cost Per Visit By Month for Regional Area IV	95

I.INTRODUCTION

A. BACKGROUND

Social and economic conditions in America, and in Texas, in particular, have resulted in a substantial and sustained increase in the number of children being cared for in day care centers, residential facilities, and family day homes. This trend is noted with concern by parents, child advocates, state legislatures and the congress, and regulatory agencies dedicated to ensuring a basic level of safety and health for children in child care facilities.

A major concern in this national focus on child care is lessening the disparity often encountered between the regulation of day care centers and family day homes. The Licensing Department of the Texas Department of Human Services (TDHS) is responsible for regulating most out-of-home child-care in Texas. In Texas, as in many states, the emphasis in regulation has historically been on day care centers which have had stricter standards and more aggressive monitoring of compliance. TDHS began to decrease this lack of parity in the 1970s focusing particularly on upgrading the regulation of RFHs in Texas.

Prior to 1976, family day homes were licensed as commercial boarding homes. The commercial boarding homes standards were unnecessarily strict for providing care in family day homes and few day home care providers volunteered to enter into the regulation process. On January 1, 1976, the Licensing Act went into effect mandating, among other things, a statewide registration program for family day care homes in Texas. The registration model adopted at that time was designed specifically to address safety and health issues as they manifest in the home environment and, compared to other types of child care centers, the standards were fewer and less stringent. The immediate result of this Act was a 640% increase in the number of family day homes regulated by TDHS over the next year.

In 1977, TDHS sponsored a national conference designed to find more creative, cost-effective methods for regulating family day homes. Ideas generated at this conference helped TDHS refine its registration model for family day homes. In 1982, and again in 1990, the minimum standards for RFHs underwent a comprehensive revision, each revision moving closer to the minimum standards applicable to day care centers, yet still sensitive to the family day home environment.

In late 1989 TDHS applied to the federal government for, and in 1990 was awarded, a grant under Section 301 of The Family Support Act of 1988 to be used for improving child care regulation and monitoring of RFHs. Project CHERISH (Children in Home Environments: Regulation to Increase Safety and Health) provided funds to TDHS to implement and evaluate several innovative strategies to strengthen regulation of family day homes. This report contains descriptions of those strategies, an evaluation of their efficacy, and other information useful for improving the regulation of family day homes.

B. FACTORS IN REGULATING FAMILY DAY HOMES

Several major factors influence the approach TDHS employs in regulating family day homes: Historical events, an unequal facility type/child ratio, and a partnership-based philosophy of regulation.

1. Historical Events

The registration model adopted in 1976 included a small and weak set of minimum standards which have grown increasingly more stringent with revisions in 1982 and 1990. The caregiver signs a form declaring compliance with these minimum standards, but no systematic statewide inspection visits have been made to RFHs. Although TDHS has conducted several small scale compliance studies in various areas around the state, in-person contact between RFH providers and regulatory representatives has been generally limited to visits for the purpose of complaint investigations.

The latest minimum standards, perhaps the most stringent registration standards in the nation, went into effect in July 1990. This latest revision of the standards, coupled with the start of a monitoring program funded by this grant, generated some anxiety among family day home care providers who historically have had limited contact with child care regulators.

2. Unequal facility type/child ratio

If each of the approximately 15,000 family day homes in Texas filled their registration capacity for children, the 90,000 children being served[1] would be about five times less than the capacity of 498,730 children for about half as many (7,060) licensed day care centers. That is, **approximately two-thirds of child care facilities in Texas are regulated to care for only about one-fifth the number of children in day care.** Ensuring a minimum level of health and safety in all regulated facilities requires innovative, cost-effective strategies and a judicious allocation of resources between the relatively numerous RFHs with relatively few children and the relatively few licensed day care facilities with relatively more children.

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[1] The maximum number of full time children allowed in RFHs is six which is the basis for this estimate although, in fact, up to six more after-school care children may be cared for.

3. Partnership Philosophy

Although fundamentally a regulatory body, the Licensing Department is committed to improving child care in Texas by forming a partnership with individuals and groups with a vested interest in ensuring the best child care possible. While maintaining the enforcement power characteristic of regulatory agencies, the Licensing Department plays two major facilitating roles: informing and empowering both child care professionals and parents.

Caregivers. Raising the professionalism of child care providers raises the level of care for children beyond what is called for in the minimum standards. The first major successful effort to organize the registered family home industry in Texas was in 1988 when the Licensing Department assisted in the creation of the state-wide Texas Professional Home Child Care Association (TPHCCA) with a membership of 235 caregivers (although local caregiver groups also existed at that time). Since then, its membership has expanded to approximately 3,000, about 20% of RFH caregivers. TDHS also encourages family day home associations in the community--at this time there are 82 such groups across the state and this number is growing.

The TPHCCA advocates professionalism in RFHs with conferences, educational programs, and lobbying efforts at the local, state, and federal level. Its members also work with other organizations, such as the National Association for the Education of Young Children, to promote the child care industry in general, and RFHs in particular. The statewide association has sponsored, along with support from TDHS Licensing Department, three annual conventions, the latest held in Houston, attended by 200 caregivers and other interested persons.

Parents. Informing parents of what to look for in day care in registered family homes and encouraging parents to monitor their children's day care help ensure that facilities, at the very least, remain in compliance with the minimum standards. TDHS provides information to the public on an ongoing basis in the form of talks, brochures, lists of facilities, and other written material.

This philosophy of partnership manifests itself at the most basic level developing regulatory programs for child care. For example, input from all groups affected by, and informed in, various aspects of child care regulation--parents, lawyers, doctors, child care professionals, and experts in fire, sanitation, and safety--is actively elicited at almost every step in revising the minimum standards.

C. THE REGISTRATION PROCESS

A family day home subject to regulation is defined by law as:

> ...a home that regularly provides care in the caretaker's own residence for not more than six children under 14 years of age, excluding the caretaker's own children, and

that provides care after school hours for not more than six additional elementary school children, but the total number of children, including the caretaker's own, does not exceed 12 at any given time. (Chapter 42, Human Resources Code.)

Family day homes with three children or less may voluntarily submit to regulation. Homes in which 7 to 12 children are cared for on a regular basis are considered group day homes and have their own specific regulatory procedures.

Family day homes subject to regulation are required by law to be registered. The process begins when a caregiver contacts a registration technician at TDHS who provides the caregiver an application, a copy of the minimum standards, checklists, and other materials for the caregiver to use to comply with the standards.

When the completed application form, with its signed self-certification of compliance with the minimum standards, is received by TDHS, a notification of registration letter, providing proof of registration and date of renewal (one year from the date of registration), is sent to the caregiver along with more educational materials. The cover letter also includes information on child care workshops and other community resources, and offers TDHS assistance in helping the provider maintain minimum standards.

Prior to July 1, 1990, this registration procedure was often completed by mail since the caregiver was not required to apply in person nor was any routine registration visit made. The 1990 minimum standards now require caregivers to attend a six-hour orientation session given by the Licensing Department in which the minimum standards are explained and information to help improve child care in RFHs is provided.

D. OBJECTIVES OF PROJECT CHERISH

Project CHERISH provided funding for two major initiatives: implementing and evaluating a monitoring program for RFHs and developing and implementing a public advertising campaign to raise public awareness of RFH regulation. The monitoring program afforded the opportunity to pursue several parallel objectives: Obtaining data about RFH facilities and caregivers, obtaining data on compliance with the minimum standards, evaluating the minimum standards, and evaluating the monitoring plan.

1. Collect data about the RFH facility, children, and caregiver

Very little is known about the typical RFH in Texas. What is known has been provided by either periodic small-sample, unannounced inspection visits in certain areas of the state, investigations of complaints against an RFH, or from personal interactions with RFH caregivers.

Information about RFHs gained through these methods has not been thorough or unbiased. In random sampling, only compliance information has been examined. In complaint investigations, the sample is preselected on the basis of received complaints and may not represent RFHs in general since most RFHs receive no complaints. In personal interactions with caregivers, the generalizability of the information gained is questionable. A major goal of project CHERISH, then, was to collect information about RFH facilities, children, and caregivers that was thought to be relevant to regulatory decision making.

2. Obtain information about compliance with the minimum standards

A major goal of Project CHERISH was to collect detailed information about compliance with the minimum standards. This information helps in designing the curriculum in RFH orientation by pinpointing areas where noncompliance is at its highest. This information is also useful for focusing future inspections on those areas where it is most likely that problems will occur. Finally, this information can be used as baseline data from which to evaluate any initiative designed to decrease noncompliance in specific areas. That is, trends in noncompliance can be used to assess how well the department is doing in helping the providers come into compliance with the minimum standards.

For the 1990 minimum standards, specific training and competency requirements of the caregiver were added, including an increase in the minimum age from 18 to 21 years old (with specified exceptions), completion of a 6-hour TDHS orientation covering the minimum standards and more when registering for the first time, certification in both CPR and first aid, and 20 hours of training in child care related topics per year.

The emphasis on training and competency is one strategy for enhancing the regulatory process of RFHs with the assumption that such training and competency will result in generally better care (and thus fewer noncompliances) and, thus, offset, to some degree, the lack of routine and mandatory yearly inspections of all RFHs. The validity of this assumption is evaluated in Project CHERISH.

3. Evaluate the minimum standards

The Licensing Department is mandated to review the minimum standards for child care at least every six years. New minimum standards for RFHs were issued in June 1976, April 1982, and July 1990. These standards are a product of input from many people and groups and are designed to reflect what the citizens of Texas consider reasonable and minimum. For the 1990 standards, for example, the department held 18 statewide public hearings and received comments from over 1,500 people, in addition to the assistance provided by parents, lawyers, doctors, child care professionals, and experts in fire, sanitation, and safety who participated in developing the minimum standards.

The 1990 minimum standards, attached as Appendix A, are divided into four sections and 12 subsections as follows:

- 1000 THE CAREGIVER AND FAMILY
  - 1100 Caregiver qualifications
  - 1200 People in the home
- 2000 THE CHILDREN IN CARE
  - 2100 The number of children in care
  - 2200 Admission requirements
- 3000 HEALTH AND SAFETY
  - 3100 Fire Prevention, sanitation, and safety
  - 3200 Nutrition
  - 3300 Telephone
  - 3400 Accidents and illnesses
- 4000 CHILD CARE IN THE REGISTERED FAMILY HOME
  - 4100 Supervision
  - 4200 Abuse or neglect of children in care
  - 4300 Activities
  - 4400 Discipline

Eight appendices give compliance requirements on:

1. Immunization and tuberculosis test requirements
2. Fire prevention
3. Sanitation
4. Safety
5. Water activities
6. Transportation
7. Kinds and amounts of foods to be served to meet nutritional needs
8. Criminal offenses from the Texas penal code

For the purposes of this study, Section 3100 was divided into seven subsections, each dealing with particular types of hazards covered in a number of the appendices. Thus 18 subsections of the minimum standards were examined in this study.

A major part of Project CHERISH was to evaluate the standards as a regulatory tool. How the standards are perceived, how the standards are applied, and how the standards are received represent the type of questions we pursued. This information will be used as the Licensing Department prepares for the mandated 6-year review required of all minimum standards for child care.

4. Evaluate the monitoring plan

This objective was concerned with ensuring that the monitoring plan was implemented as efficiently as possible. The evaluation of the monitoring plan began with a pilot study in which problems encountered were identified and resolved. An ongoing feedback system was instituted to identify problems as they arose. Primarily, however, this objective was to be met by linking data about implementing the monitoring plan with costs.

5. Implement a state-wide public information campaign to increase parents' motivation to monitor their child care

Unlike the educational system, the child care system has no formalized parent networking groups such as the PTA or PTO. There are local, relatively informal parent groups, and many child (care) advocacy groups such as the Children's Defense Fund, include parents whose children are in day care, including registered family homes. Still, the dissemination of information about child care--what is good, what is bad, how it is regulated, what to look for, etc.--is hampered by a lack of formalized parent networks.

A large-scale public information campaign was developed to inform the public, particularly parents, about the regulation of day care in Texas, particularly the regulation of RFHs. The development of this campaign took well over a year and involved a major corporation, as well as many smaller groups and individuals. The development of this campaign is documented and the implementation is described.

II.METHODOLOGY

A. IDENTIFYING THE SAMPLE

The goal was to select a twenty percent sample of RFHs which could be used to draw conclusions about all RFHs in Texas but which could also provide information about RFHs in particular localities in Texas. The Licensing Department has field offices statewide which have been organized into 12 regions.[1] A statewide random sample of 2,989 RFHs stratified by the RFH population in each of the 12 administrative field regions in Texas was drawn.

The actual number of visits completed was 3,036 (249 pilot cases, 2813 actual) distributed among the 12 regions as follows:

REGION	Target	Completed	REGION	Target	Completed
01	95	98	07	101	103
02	78	79	08	274	247
03	43	47	09	299	333
04	163	186	10	69	61
05	769	756	11	663	674
06	380	421	12	55	42

The strategy used to identify the sample was influenced by characteristics of RFHs that made a large number of them unsuitable for monitoring:

(1) The RFH is also a private residence. Unnecessary intrusion into a caregiver's life by entering and monitoring her home when the RFH is not operating is unwarranted.

(2) The most complete information about an RFH will be obtained when children in care are present at the time of the monitoring visit. When children are not present, many of the standards cannot be evaluated for compliance. The likelihood of compliance with minimum standards will thus be greater for these RFHs only because they are not being evaluated on all standards. Separate analyses would be necessary for RFHs with and without children present during the monitoring visit thereby decreasing the sample size.

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[1] Concurrent with the implementation of this study, the Licensing department reorganized its field administration, combining the 12 regions into four regional areas.

(3) Many caregivers do not care for children full time, especially during the summer. Many go for some periods without children and some operate only in the morning or afternoon.

(4) The ongoing activities of the RFH may include extended day visits (e.g., field trips) outside the home.

These characteristics, and the need for unannounced visits, formed the basis for the guidelines for determining the appropriateness of monitoring visits, attached as Appendix B. These guidelines resulted in monitors finding active RFHs in an estimated 61 percent of their visits during the pilot visits. (Note that this estimate is based on summer visits when a decrease in the number of active RFHs is expected.)

To minimize travel costs the sampling plan incorporated a replacement strategy which allowed the monitor to replace an RFH on the sample that was found to be not operating with an RFH in a randomly constructed replacement list within the same zip code. This strategy is detailed in Appendix C.

To ensure that the sample was as up-to-date as possible, the sample size was divided by four and sampling objectives set for each quarter. A new quarter-based random sample (and random replacement list) was drawn every three months from the list of all RFHs in the state that had not been monitored.

B. MONITORS AND MONITOR TRAINING

Fourteen monitors were hired to conduct the monitoring visits and to provide technical consultation to caregivers about how to meet and exceed the minimum standards. The minimum qualifications included a bachelors degree and two years of full-time experience in direct social service work, day care administration, child education, or day care licensing or, alternatively, a masters degree in social work, child development, early childhood education, or related field. Together, the group had a depth and breadth of experience in child care that served this project well and provided a rich source of information for each individual monitor.

Before making any visits, each monitor spent three days observing in an operating RFH. Monitors were also trained as a group in an intensive week-long seminar in interpreting the minimum standards, interacting with caregivers, and completing the necessary data collection forms. Finally, monitors were provided with information about resources for RFH caregivers. Training was similar to basic job skills training given to new licensing representatives.

Each monitor then evaluated RFHs for six weeks, completing an average of 12 visits each. These 249 visits served as the pilot study in which information was obtained to develop objective questionnaires, to identify issues and problems in monitoring, and to sharpen monitors' consulting skills.

Monitors then returned for another week-long group training seminar. During this latter seminar new forms were developed to collect data based on input from the monitors, interpretations of the standards were clarified, sources of information were exchanged, and experiences in monitoring visits were shared.

C. SURVEY INSTRUMENTS AND DATA

Tracking instruments were developed to collect information about the monitoring process and monitor performance. Questionnaires were developed to assess compliance with the minimum standards, gather general information about each RFH, gather specific information about each caregiver, and assess each caregiver's response to the monitoring process.

An initial set of questionnaires used in the pilot visits contained primarily open-ended questions to gather information. This information, and feedback from the monitors in their second training session, was used to develop the final research instruments described below; use in the field began August 13, 1990. The pilot and research instruments are attached as Appendix D. Descriptions of the instruments follow.

Form	Information
Tracking sheet	Disposition of attempted visits; record of active complaints
Cover sheet	Identifying info; children and adults in home; times and dates
Minimum Standards Evaluation Checklist	Compliance data; structural/environmental information about the RFH; observability; technical consultation given
Standard Interview with caregivers	Perceived difficulties in complying; caregiver professional associations, training and education; needs from TDHS
Questionnaire for Project Staff	Ratings of quality of care, safety, cleanliness of RFH; ratings of caregivers' reaction, interest, and effectiveness; environmental information; percent of time in various tasks
Caregiver mail-in questionnaire	Ratings of monitor; perception of visit; perception of standards

1. Tracking Sheet

Monitors recorded on a tracking sheet the progress and disposition of each RFH on the sample list for which a visit was attempted. This tracking sheet was kept by the monitor in the field and a copy submitted from each monitor once a month to the state office for review and analysis.

Information was collected about the number of times and dates the monitor attempted to call and/or visit the RFH, the reason why a standard-by-standard evaluation could not be completed for the RFH (if applicable), and whether a follow-up visit was necessary. This information was used to evaluate the adequacy of the sampling strategy and the progress of the research plan over time.

2. Cover Sheet

A cover sheet for each visit contained basic identifying information--name and address of caregiver, the region in which the RFH is located, and the facility number given the RFH by TDHS. Also collected was specific information about the children and adults present during the monitoring visit including age, sex, evidence of meeting specific medical requirements set by the standards, and, for adults, their relationship to the caregiver and whether they have been screened by TDHS for previous criminal convictions.

The time of arrival and time of departure, the date the required entry into the agency's computer-based tracking system, ACCLAIM, was made, and the date the survey packet was received in the state office were also entered on this sheet.

3. Minimum Standards Evaluation Checklist

A checklist was developed specifying each component of each standard. Monitors determined whether or not the RFH was in compliance with each component. In addition, the checklist was designed to collect information about the RFH relevant to the standards. Specifically, information was collected about--

(1) features of the home (i.e., number of fireplaces, smoke detectors, exits, toilets, lavoratories, and pets),

(2) the presence of outside play structures (i.e., swings, slides, climbing structures, gliders, and merry-go-rounds),

(3) the presence of nearby bodies of water (i.e., swimming pools, wading pools, ponds, and others), and

(4) the presence of particular safety items (i.e., water lifesaving devices, posted telephone numbers, and first aid supplies).

Two additional pieces of information were collected along with the compliance ratings. Monitors indicated for each standard whether compliance was determined by direct observation and/or discussion with the caregiver. Monitors also indicated for each standard whether technical consultation was provided during the visit or whether consultation was requested by the caregiver for a later time. This information was used in evaluating the minimum standards.

4. Standard Interview with Caregivers

At the close of the monitoring visit, the monitor interviewed the caregiver with a set of questions designed to assess--

(1) their perceived difficulties in meeting the standards,
(2) the level of caregiver involvement in related organizations, such as food assistance programs and child care referral networks,
(3) the depth and breadth of previous training related to operating an RFH, and
(4) training or assistance the caregiver would like to see offered by TDHS.

This information was gathered to help policy makers create strategies to help caregivers overcome obstacles that prevent them from meeting or exceeding the minimum standards and to suggest approaches to building effective training delivery systems. Information about previous training was used to test a basic assumption in the regulatory approach to RFHs--that training of the caregiver is directly related to a safe and healthy environment for children in care.

5. Questionnaire for Project Staff

As soon as possible after the monitoring visit the monitor recorded impressions of the RFH which included--

(1) general perceptions of quality of care, safety, and cleanliness of the RFH facility,
(2) perceptions of the caregiver's
    - reaction to the standards and the monitoring visits,
    - interest in the professional aspects of running a family day care home, and
    - effectiveness with the children in her care, and
(3) perceptions of child care practices, including the adequacy of equipment and materials, record keeping, maintaining an appropriate environment for children, and having appropriate activities for the children in care.

The monitor also identified the type of building that houses the RFH (e.g., apartment, single family residence), whether it is in a rural, urban, or suburban area, and the condition of the immediate neighborhood (i.e., cleanliness, traffic conditions, and safety). Any unique characteristics or activities of the RFH, both positive and negative, was also noted by the monitor.

Finally, the monitor estimated the percentage of time during the actual monitoring visit spent on each of three tasks--observation, consultation, and paperwork (to sum to 100%).

The monitor's assessment of the RFH was used with other information to determine the relationship between compliance with the standards and the safety and health of children in care. The identification of unique hazards and practices increases the information base that can be made available to caregivers. The follow-up and time percentage information was used to track monitor performance.

6. Caregiver Mail-in Questionnaire

At the end of each monitoring visit the monitor gave the caregiver a one-page questionnaire and a postage-paid envelope in which to return it to the state office of TDHS. The caregiver was asked in this questionnaire to rate the monitor and the monitoring visit on several dimensions. The caregiver was also asked her opinion about standards and the need for monitoring visits. The caregiver could choose to return the questionnaire anonymously by not writing in her name. The response rate for this questionnaire was 47% (n=1483). Three percent of the returned questionnaires were in Spanish.

The data from the caregiver questionnaire was used to identify aspects of the monitoring process that are perceived negatively by caregivers. It also was used to provide feedback to the monitors about how their visits were perceived and to TDHS about caregiver response to the regulatory process and the new standards.

7. Travel and salary cost data

The actual cost of monitoring RFHs for this project was assessed by comparing certain work performance indicators with expenditures in travel and salary. The primary work performance indicators in monitoring RFHs are the number of active RFHs for which a minimum standards evaluation is completed and the number of operating RFHs for which a visit was made but no minimum standards evaluation was completed. These indicators were compared with expenditure data to determine the average cost of a standard-by-standard evaluation (given the level of non-operating RFHs in the sampling plan) and the costs of travel.

8. Data from a previous licensing study

Where feasible, the results of this study are compared with the results of a previous study of 880 RFHs completed in 1978[2]. The minimum standards in place in 1978 were quite different from those in place today and direct comparisons can only be made on several key standards. Primarily, the point of contact between these two studies is with demographic data about the RFH.

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[2] *Registration: Evaluation of a Regulatory Concept.* Texas Department of Human Resources, Licensing Branch. Joanna E. Nowak, 1978.

III.THE FACILITY, CHILDREN, AND CAREGIVER

A. THE FACILITY

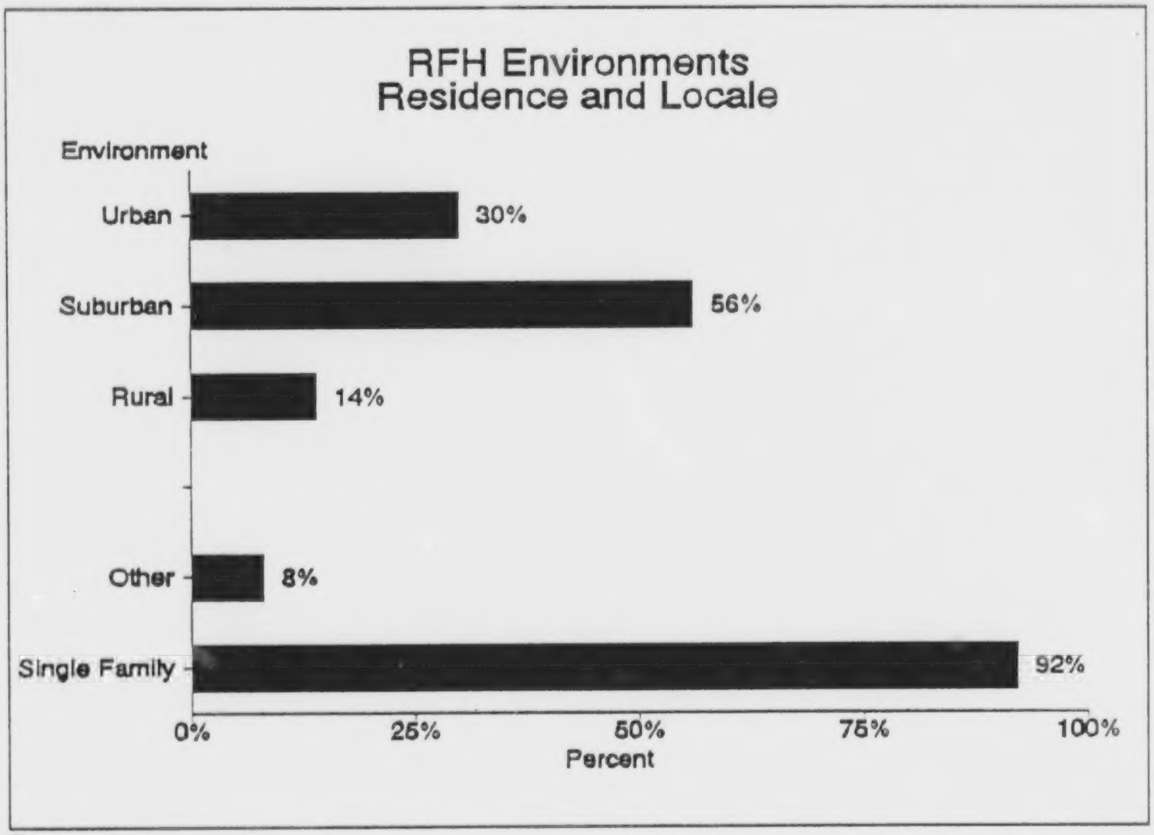
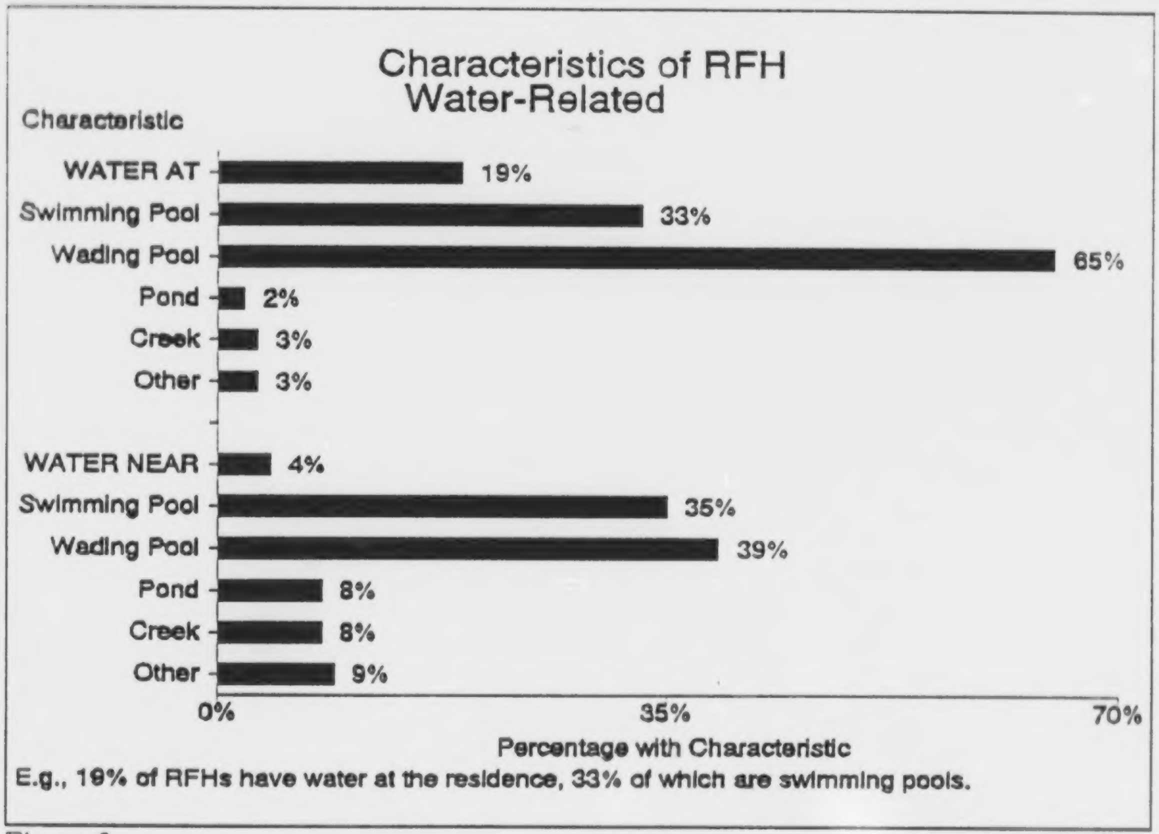


Figure 1

Almost all (92%) RFHs are located in a single family home. This is similar to the 94% figure for "private homes" found in the 1978 RFH study. The majority are in a suburban setting (56%) with 30% in urban locations and 14% in rural locales. The water supply is typically public (98%) versus private (e.g., a well) and the sewage system at the facility is also typically public (95%) rather than private (e.g., a septic tank).



E.g., 19% of RFHs have water at the residence, 33% of which are swimming pools.

Figure 2

1. Outside

Seventy four percent of RFHs have no bodies of water at or near the facility.

Nineteen percent of RFHs have water at the facility. Swimming and wading pools accounted for 33% and 65% of water at the RFH, respectively. (Note that an RFH could have both a swimming and wading pool.) Two percent of these RFHs had ponds, 3% had a creek. Another 3% had some other type of water, primarily hot tubs and jacuzzis.

Water near the RFH was observed for only 4% of the RFHs with the primary bodies being swimming (35%) and wading (39%) pools. Ponds (8%) and creeks (8%) were also nearby some RFHs. Nine percent had other types of water such as drainage ditch, canal, bayou, or stock tank.

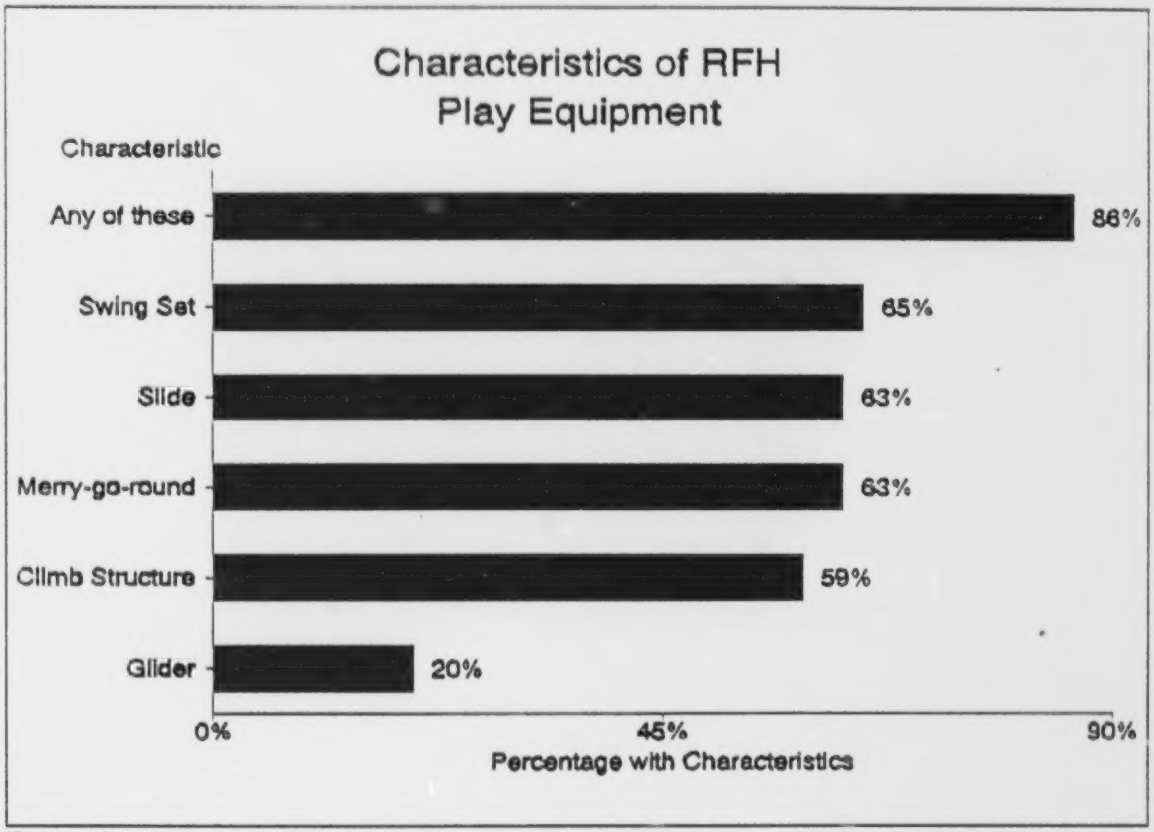


Figure 3

Eighty-six percent of RFHs have at least one major piece of outdoor play equipment. The most commonly observed piece of outdoor play equipment was a swing set (65%), followed closely by slides (63%), revolving devices (63%; e.g., merry-go-rounds), and climbing structures (59%). Twenty percent of RFHs have a glider at the facility.

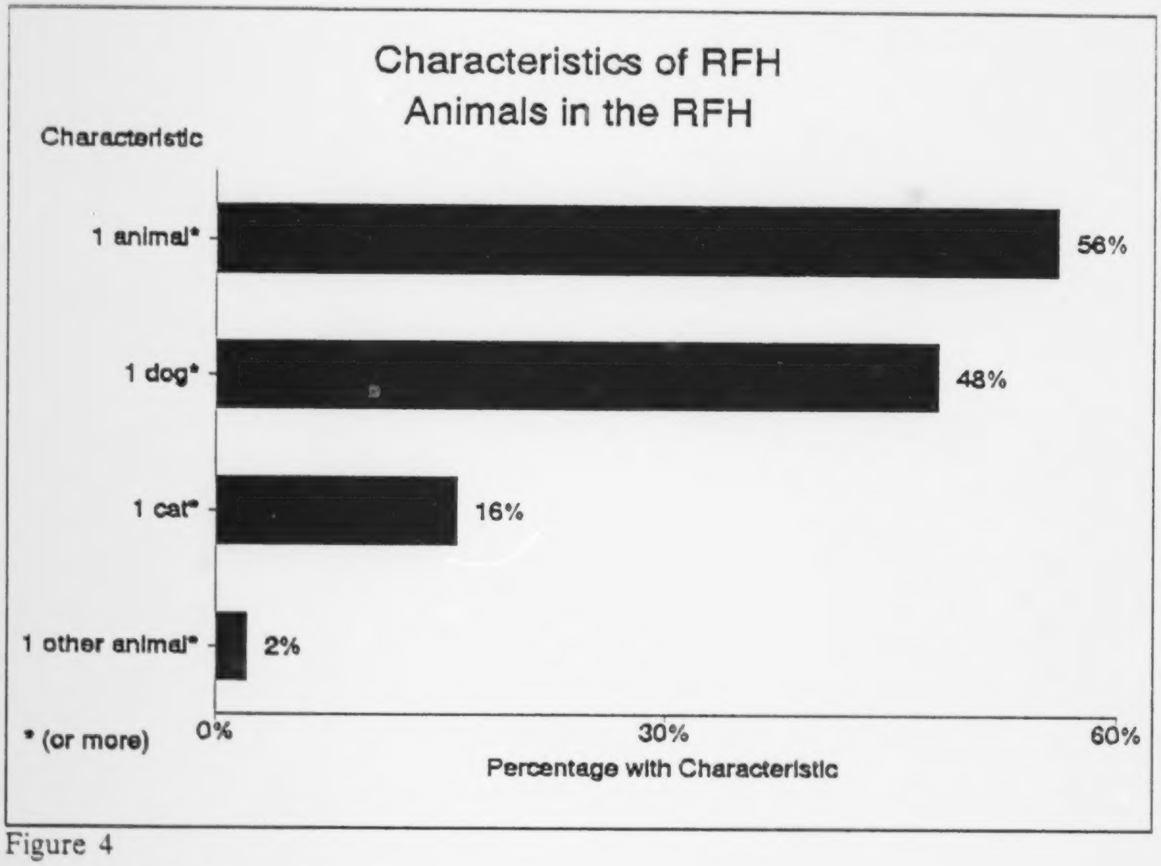


Figure 4

Fifty-six percent of RFHs have at least one animal. Forty-eight percent have at least one dog, 16% have at least one cat and 2% have at least one other type of animal.

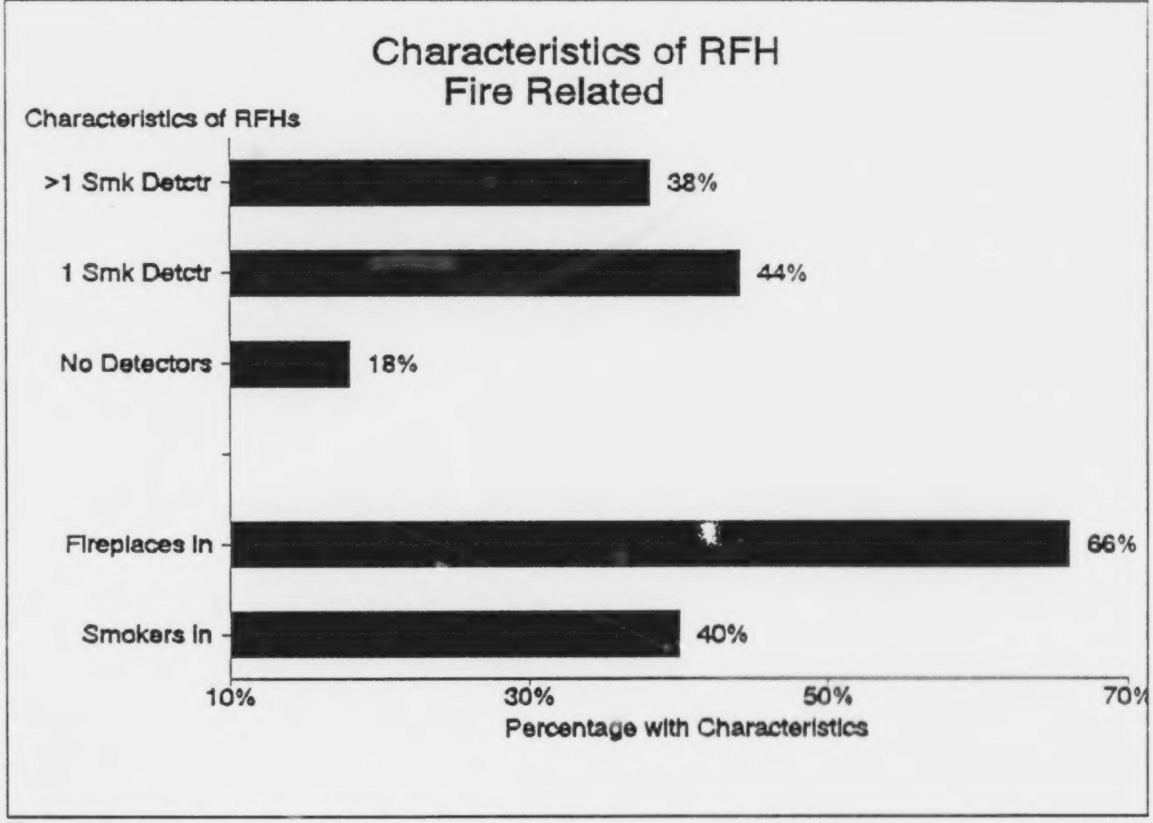


Figure 5

2. Inside

With respect to the interior of the RFH, two or more entry/exit doors are present in 98% of the RFHs. Two or more windows are present in 95% of the RFHs. When only one door is present there is at least one window that can be used as an exit. Most RFHs have one (31%) or two (61%) toilets and one (31%) or two (60%) lavatories. Two percent of RFHs do not have running water as evidenced by the lack of both a toilet and a lavatory.

Sixty-six percent of RFHs have a fireplace. The majority have one (44%) or two (27%) smoke detectors but 18% have none. Sixty percent of the caregivers report that no one living in the RFH smokes tobacco products on a regular basis.

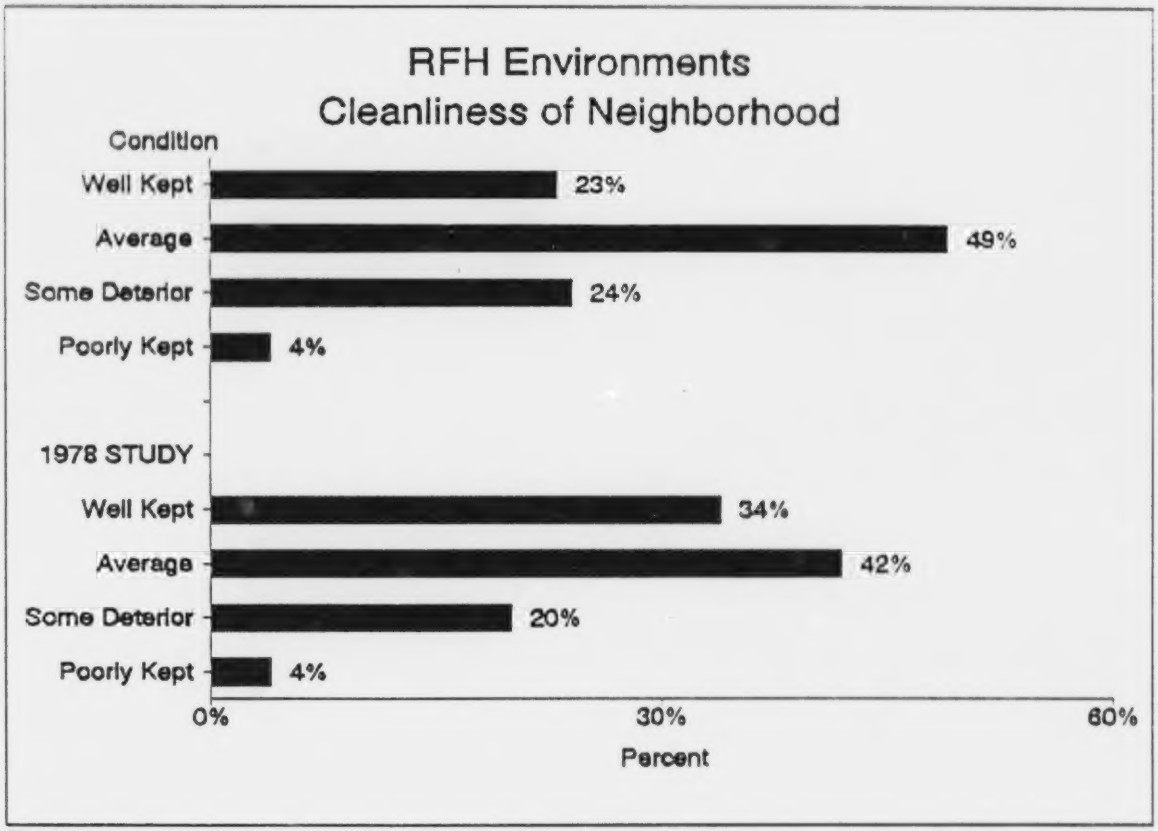


Figure 6

3. Neighborhood

Monitors rated several features of the neighborhood in which the RFH was located. In rating the cleanliness of the surrounding neighborhood, 23% of RFHs were in well kept neighborhoods while 49% were in average neighborhoods. There was some deterioration noted in 24% of the neighborhoods and 4% were rated as poorly kept.

For comparison, the 1978 study also rated the neighborhood of the RFH using the same scale. In that study, 34% were well kept, 42% were average, 20% showed some deterioration, and 4% were rated as poorly kept.

Only 1% and 3% of the neighborhoods which housed RFHs were considered very high risk or high risk for children, respectively. Some moderate risk was noted for 29% of these neighborhoods with 67% rated as low risk.

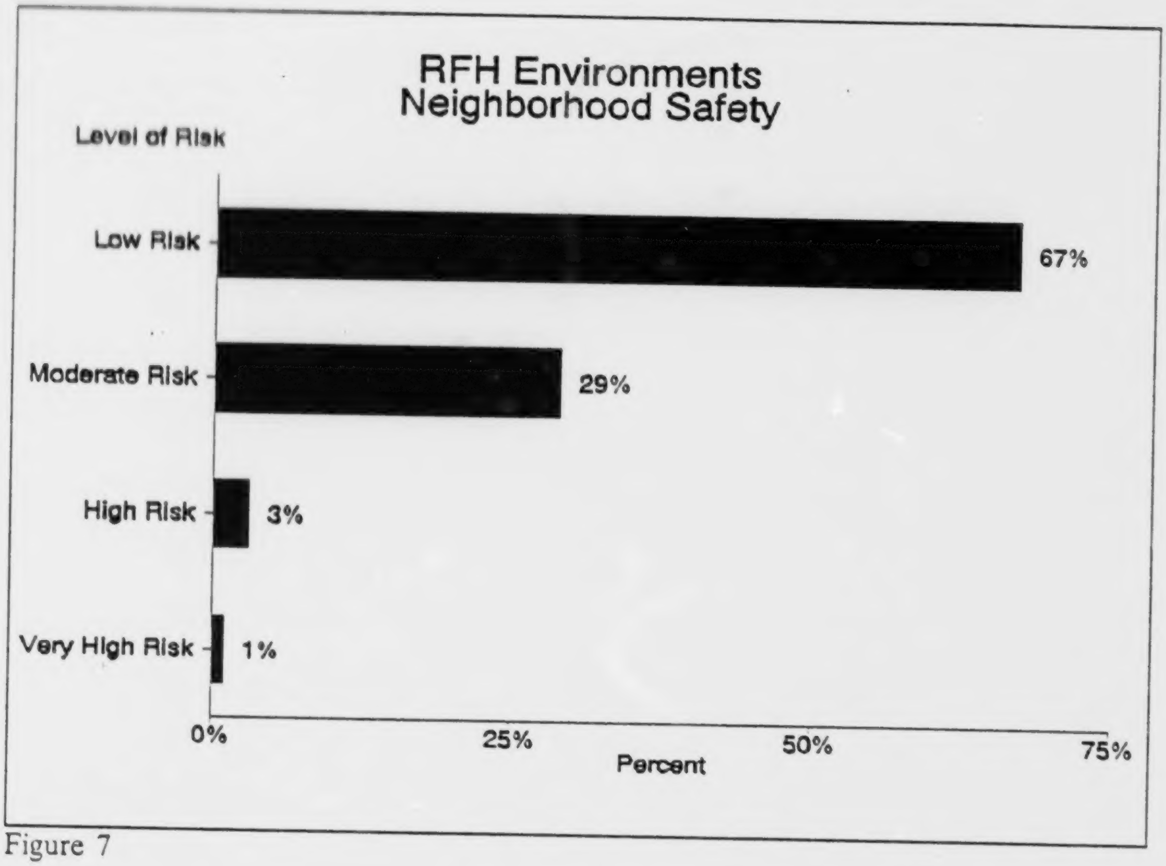


Figure 7

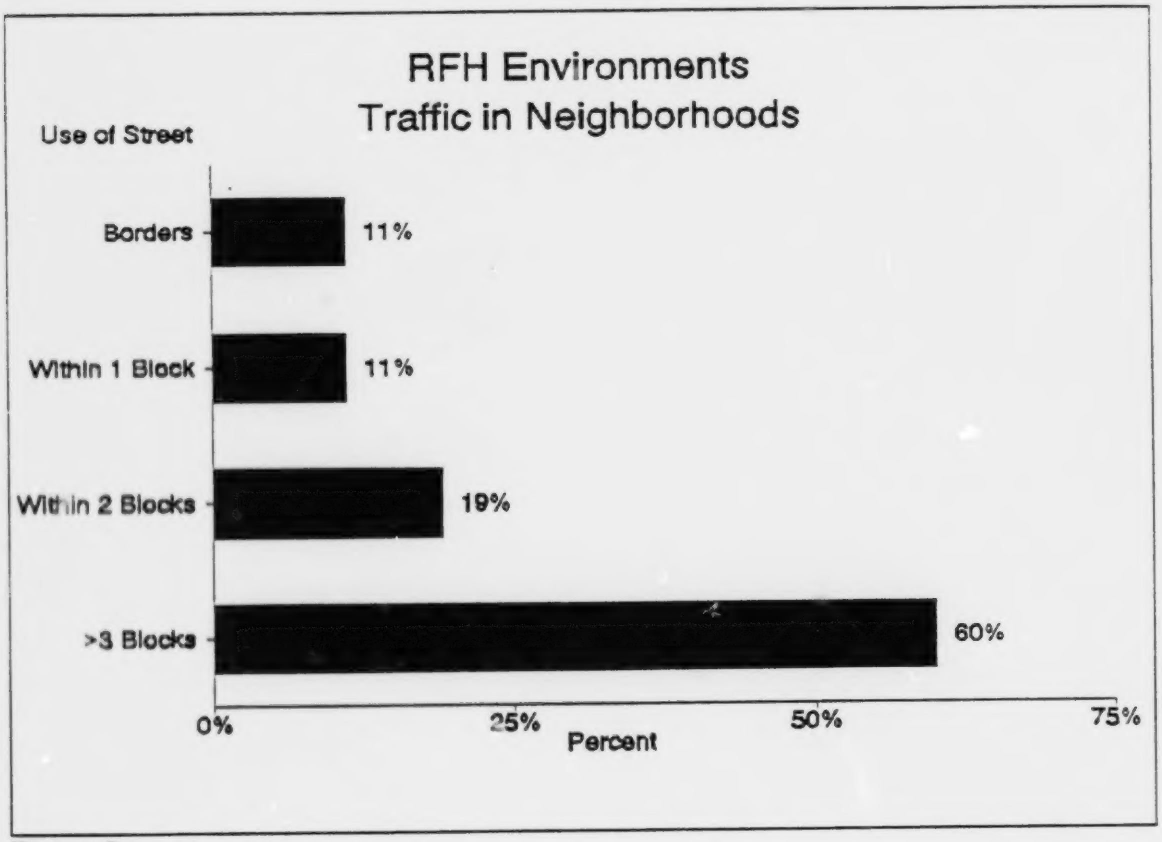


Figure 8

Most RFHs (60%) are more than 3 blocks away from a heavy use street. About 1 in 10 RFHs border a heavy use street, with the remaining within one (11%) or two (19%) blocks of one.

B. THE CAREGIVER

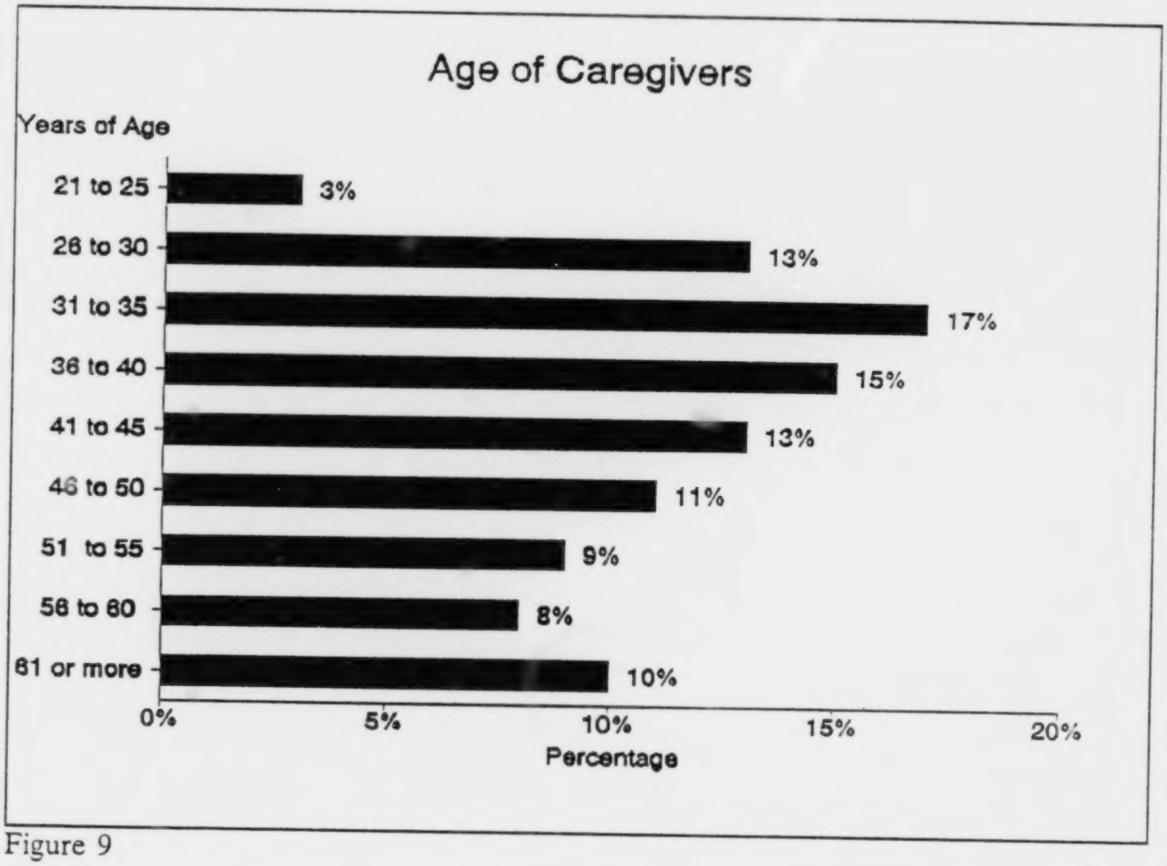


Figure 9

1. Age and sex

The mean age of caregivers is 44 years old but this figure does not accurately reflect our population of caregivers. Less than 1% do not meet the minimum standard age requirement of 21 years and only 3% are from 21 to 25 years old. Otherwise there is a distribution of ages across all age groups which has a small peak at the 31 to 35 year old age group and lessens slightly over each older age group. The age range of caregivers is from 20 to 91 years old. All but eight caregivers interviewed in this survey were female.

A decline in the age of caregivers since the 1978 study is noted. In that study the mean age of the caregiver was 46 years old and the distribution of ages reflected somewhat more caregivers in the higher age brackets. For example, in this study, the percentage of those 61 and over (10%) is less than half of the comparable age group found in 1978 (22%). Caregivers in their thirties rose from 24% in 1978 to 32% in this study.

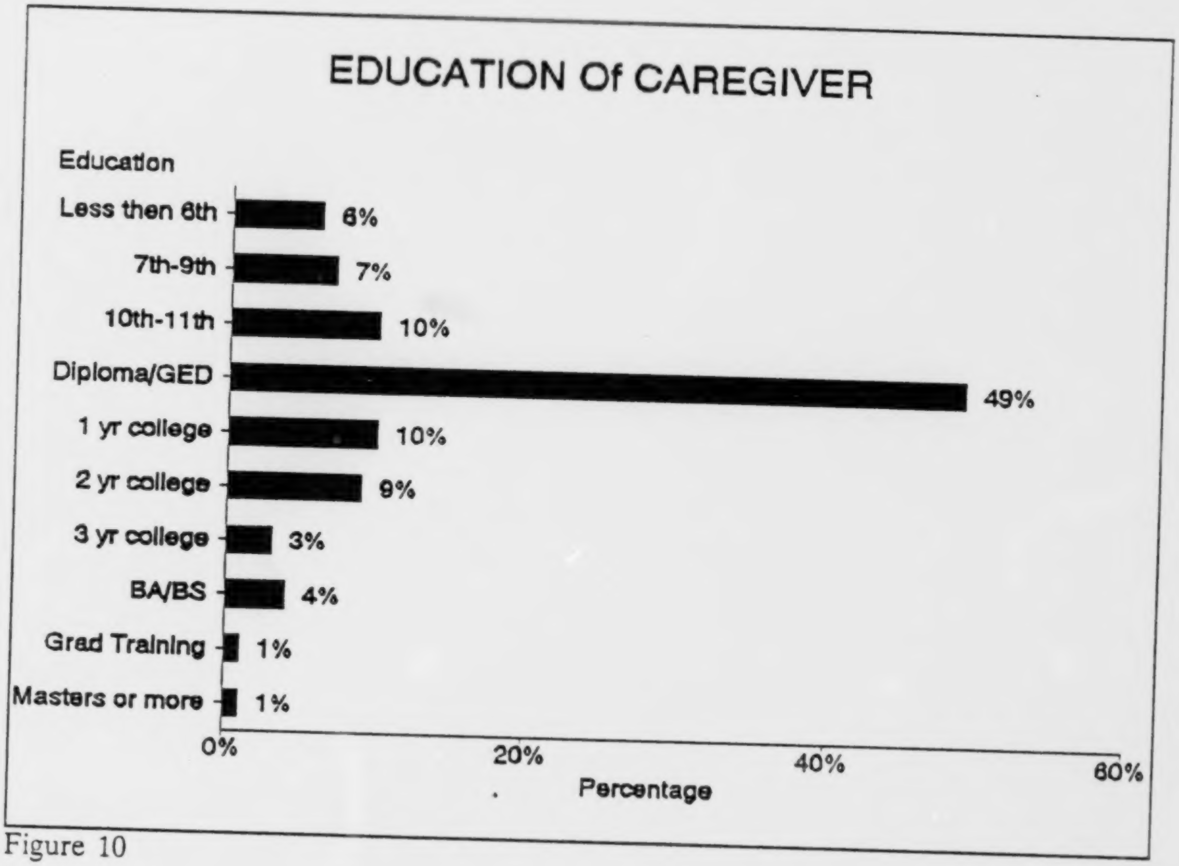


Figure 10

2. Education

About 1 of 4 or 5 caregivers (23%) in Texas do not have a high school diploma or GED. On the other hand about 1 in 4 RFH providers (28%) have one year of college or more.

The education level of caregivers has increased considerably since 1978. Then, 43% of caregivers did not have a high school diploma compared to 23% today. The percentage of college graduates has almost doubled since 1978 from 3 to 6%.

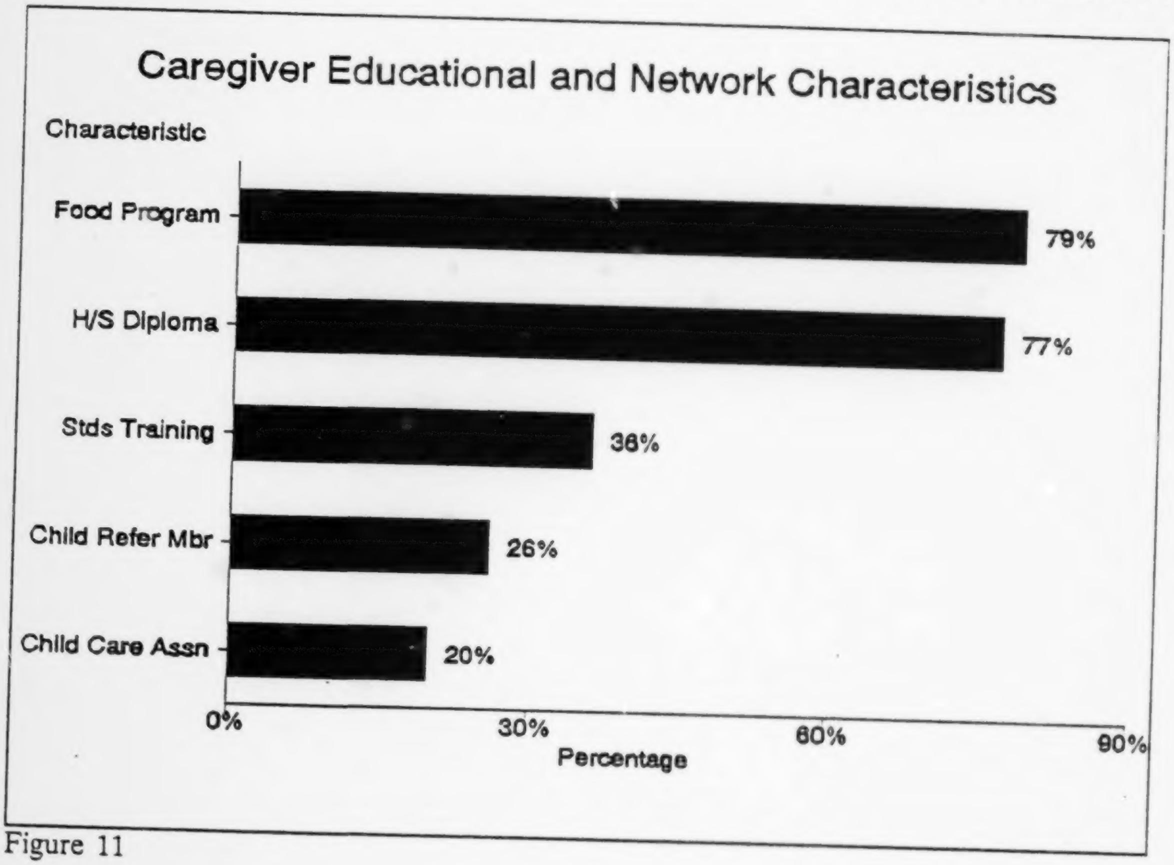


Figure 11

3. Memberships

About 4 of every 5 caregivers (79%) belong to a food program but only 26% belong to a child care referral organization. Only 1 in 5 (20%) caregivers belongs to either a local, statewide, or national child care association.

4. Familiarity with standards

Responses from the anonymous surveys indicate that 85% had received the July, 1990, minimum standards. Ninety-five percent were at least moderately familiar with the standards and 65% were "Very" or "Especially" familiar with the standards.

C. CAREGIVER TRAINING

Caregivers were asked what areas of training they had received, where they had received their training, how much training they had received in child care related topics, and what training they would like to see TDHS offer.

1. Minimum standards training

The Licensing Department sponsored a series of minimum standards training sessions to train RFH providers on the July 1990 standards. Thirty-six percent of caregivers stated that they have completed the 3-hour training. The two major reasons given for not attending minimum standards training were inconvenient times (37%) and not knowing about the training (34%). Seven percent claimed no interest in attending, 5% claimed not enough notice was given for the training, and less than 1% noted cost as a factor. Of the 17% who answered "Other", the major reasons given were transportation problems (especially "too far to travel"), location of the training (presumably a transportation issue), and language issues (both foreign language barriers and the inability to read/write English).

2. Community college training

We examined caregivers' participation in three major community college programs in child care: Child Development Associates Credential, AA in Child Care, and Community College Certificate in Child Care. Less than 3% of caregivers reported having obtained these landmarks with over half of these (55%) reporting a Child Development Associates Credential.

3. Other training

The following chart shows the percent of providers who report having received training in the topics listed. Most frequently cited were safety (73% of providers have received their training in this area), nutrition (68%), health (59%), and child development (54%). The least frequently cited training areas were communication (23%), parent involvement (23%), and community resources (19%).

Training Area	Percent of Providers	Percent of all training areas
Safety	73	19
Nutrition	68	18
Health	59	13
Child development	54	10
Sanitation	46	8
Discipline & guidance	46	7
Age/developmentally appropriate activities	41	6
Risk reduction/ management	33	6
Business management	31	5
Communication	23	3
Parent involvement	23	3
Community resources	19	2

Providers regularly checked more than one training area. The right hand column lists the percent of responses for each training area using all responses as the divisor. Thus, for example, safety accounts for 19% of all training received.

D. PLACE OF TRAINING

Caregivers were asked where they obtained their training. The following table shows the percentage of caregivers for each type. The most frequently noted source of training was from food program sponsors (52%) where 1 of 2 caregivers have received training. The "Other" category was cited by 48% of caregivers. An analysis of other cited institutions revealed that TDHS (44%) and the Red Cross (19%) accounted for most of these responses. The American Heart Association (11%), correspondence courses (9%), and local hospitals (8%) were also frequently cited. Churches, fire departments, EMT units, health department, YMCA, city government, conferences and others made up the final 9% of caregivers citing "Other."

Institution	Percent of Respondents	Percent of Institutions Cited
Food program sponsor	52	33
Other	48	36
Consultant	27	14
Child care association	20	9
Junior college	19	4
University/4 year college	5	3
County extension office	5	2
Technical/vocational school	2	1

Providers often cited more than one institution. The percent of the specified institution cited over all institutions cited is given in the right hand column of the table. Thus, food program sponsors account for 33% of all training received.

E. HOURS OF TRAINING

The average number of clock hours of training since February 1990 was 14 and the average number of reported hours received over the past two years was 19.

1. Caregiver characteristics and training hours

The following table shows the differences in average training hours for differences in education and organizational membership. Those who have a high school diploma, are child care association members, belong to a child referral service, belong to a food program, or attend minimum standards training all have more training hours since February 1990 and for the past two years. The differences for the minimum standards training are due, in part, to the 3 hours credit provided for that training but this does not account for the entire difference between those who have and have not attended. All differences in training hours are statistically significant.

Characteristic	Since February 1990	Past two years
High School Diploma		
Has	13.2	18.5
Does not have	11.5	14.5
Child Care Association		
Member	20.2	28.1
Non-member	11.4	15.5
Child Referral Service		
Member	17.3	25.1
Non-member	11.4	15.0
Food Program		
Participant	13.8	19.1
Non-participant	10.1	12.8
Minimum Standards Training		
Attended	17.2	23.1
Not attended	11.0	15.4

F. TRAINING SUGGESTIONS

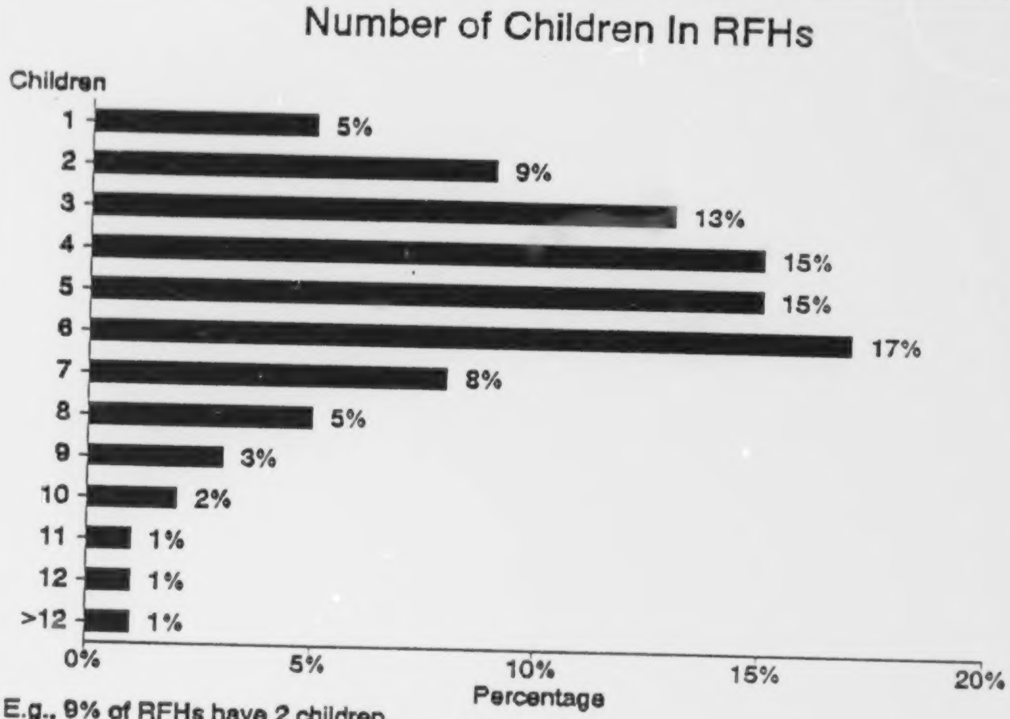
About 1 in 4 caregivers gave training suggestions for TDHS. The single most frequently cited training requested was age/developmentally appropriate activities. Business management/practices, positive discipline/guidance, and child/age development were also frequently mentioned.

These training requests were grouped by area and this grouping is presented below. The largest group is the child development/psychology (45% of responses) followed by administrative training (22%). Health and safety is also frequently mentioned (15%).

Training Requested	Frequency
Child development/psychology	
-Age/development appropriate activities	174
-Positive discipline/guidance	117
-Child/age development	116
-Behavioral problems (biting)/hyperactivity	27
-Communicating with children of all ages	16
-Potty training	4
TOTAL	454

Training Requested	Frequency
Administrative	
-Business management/practices	145
-Taxes - help, tax breaks	26
-Keeping records/books	11
-Time management/organization skills	11
-Risk management/reduction	10
-Insurance coverage	7
-Legal-Collecting fees, contracts, legal rights	6
TOTAL	216
Health and safety	
-Sanitation	42
-Safety/emergency situations	39
-Health	34
-CPR/First Aid	29
-Childhood diseases	5
TOTAL	149
Self-help	
-Stress management/burnout/self-esteem	37
-Dealing with own family/children in child care	5
TOTAL	42
Special needs	
-Recognizing child abuse/what to do about it	5
-Care for special needs/handicapped	4
-Drug addiction and children	1
-Helping children deal with traumatic events	1
-Caring for AIDS babies	1
TOTAL	12
Special topics	
-Parents-Communication, involvement, difficulties	67
-Nutrition, menu planning, snacks, food programs	41
-Required training	18
-Minimum standards	10
TOTAL	136

G. THE CHILDREN



E.g., 9% of RFHs have 2 children.
Note: 74% of RFHs have six or fewer children.

Figure 12

Registered family homes in Texas have an estimated 68,640 children in care at any given time, 76% of the capacity for the number of homes registered.

On average, 5 children are being cared for in an RFH. Seventy-four percent of RFHs have six or fewer children present. Eight percent have 9 or more children. About half the children in RFHs are female and half are male. Seventeen percent of RFHs, however, have no female children in care and 18% have no male children in care.

In the 1978 study, about 5 children were typically in care in the RFH and about half were male and half were female. At that time, however, 85% of RFHs had six or fewer children compared to the 74% found in this study.

One or more infants (0-17 months) are present in 63% of RFHs. Preschool age children (18 months to 5 years, if the 5 year old is not in school) are more typically found with 88% of RFHs having at least one preschool age child. The least likely age group to be found in RFHs is the school-age group (5 years, if in school, or older) with at least one such child in only 35% of the RFHs.

In total percentages, preschool age children make up most of the population of children in RFHs (59%), followed by infants (23%) and school age children (18%). Note, however, that most monitoring visits were probably completed while school-age children would be in school.

H. QUALITY AND CAREGIVER PRACTICES

1. Snacks and meals provided

Monitors asked caregivers what meals and snacks are typically provided to children in their care. The most striking observation is that only about 1 in 3 provide morning snacks.

Snack/meal	Percent serving
Breakfast	76
Morning snack	36
Lunch	93
Afternoon snack	93
Dinner	21

2. Rating other aspects of the RFH

Monitors rated the RFH, the caregiver, and caregiver practices on a number of dimensions. In some cases, the ratings could not be made; for example, if the monitor did not observe the caregiver interact with a parent. The percentage of responses made for each response alternative--poor, fair, good, very good, and excellent--are given for each dimension in the table below.

Dimension	Poor	Fair	Good	Very Good	Excel-lent
Overall quality	1	11	43	34	12
Overall safety inside	1	13	44	31	11
Overall safety outside	3	18	45	26	8
Overall cleanliness	2	13	40	32	13
Understand standards	3	17	38	30	12
Willingness to comply	1	8	36	35	20
Cooperation	1	4	35	38	23
Chance for correction	1	9	34	36	20
Interest in training	5	22	34	27	13
Professional bearing	4	20	38	27	12
Effect. child care practices	2	14	39	34	12
Degree of nurturing	1	9	37	36	18
Children's routine/activities	2	16	42	30	10
Equipment/materials	2	16	40	32	10
Inside physical environment	2	14	44	30	10
Outside physical environment	3	20	43	26	7
Crowdedness	3	15	40	30	13
Provider-child interaction	1	9	38	36	17
Provider-parent interaction	0	7	47	31	15
Handling outside interference	1	9	43	31	16
Record keeping/administrative	10	21	33	24	13

3. Four major aspects of RFHs identified

To determine the relationship among the twenty-one dimensions rated by the monitors, a factor analysis was performed. A factor analysis groups dimensions that consistently show highly similar response patterns into factors. The factor analysis searches for all identifiable response patterns and, using statistical criteria, chooses those patterns, or factors, that are the most clear and that differ the most from each other. A dimension is placed in a factor because it is most like the pattern that defines that factor and most unlike other patterns that emerge. A high score on a factor indicates that the monitor rated the RFH high on all the dimensions in that factor. A low score indicates low ratings on all the dimensions.

Responses to each of twenty-one dimensions rated by the monitor were given a numerical score as follows: poor (1), fair (2), good (3), very good (4), or excellent (5). A principal components factor analysis of these figures using oblimin rotation resulted in four definable factors.

FACTOR 1 - ENVIRONMENT	**FACTOR 2 - CAREGIVER**
Outside physical environ.	Willingness to comply
Overall outside safety	Chance CG will correct
Inside physical environment	Level of cooperation
Overall inside safety	Interest in training
Overall cleanliness	Professional bearing
Equipment & materials	Understands standards
Crowdedness	Record-keeping ability
FACTOR 3 - CHILD CARE	**FACTOR 4 - RELATIONS**
Degree of nurturing	Provider/parent interaction
Provider/child interaction	Handle outside interference
Effective practices	
Overall quality	
Child's routine/activities	

To interpret a factor, the dimensions within that factor are examined for some common theme or motif which provides an explanation of similarity.

Factor 1 contains seven items relating primarily to the immediate physical environmental features of the RFH. A high score on this factor would reflect a facility and equipment that was rated safe, clean, not crowded, and generally well maintained.

Factor 2 contains seven items relating to the caregiver. A high score on this factor indicates a caregiver who was rated as both motivated and able to meet the responsibilities of being a child care provider.

Factor 3 contains five items about child care practices. A high score on this factor means the caregiver was rated as skilled and effective in delivering care to her children. Note that this factor includes the item rating overall quality of the RFH.

Factor 4 contains two items pertaining to the caregiver's relations to other persons likely to be in the home. A high score here indicates that the caregiver was rated as able to balance the ongoing demands of child care with the periodic interruptions of parents and others (e.g., the monitor).

4. Relationship among the four factors

The correlations between the four factors are shown below. All correlations except the one between the child care and caregiver factors are significant (p<.001).

	Environment	Caregiver	Child care
Caregiver	-.07		
Child care	-.41	.01	
Relations	.41	.11	.37

The relations factor has significant and positive correlations with the other three. A clean and safe environment (.41), effective child care practices (.37), and a motivated caregiver (.11) are associated with the ability to meet the demands of others likely to come into contact with the RFH, generally, parents and TDHS staff.

A clean and safe RFH environment is negatively associated with effective child care practices (-.41). A higher rated environment is more likely in RFHs in which there is lower rated child care. This negative relationship may reflect two distinct approaches to operating an RFH: one that emphasizes creating an appropriate environment and deemphasizes interacting with the children versus one that emphasizes interacting with the children and deemphasizes the environment.

There is also a slight, but significant, tendency for the caregiver rated as less motivated to be rated high on the environmental aspects of operating the RFH although there is no reliable relationship between the caregiver's rated motivation and the rated effectiveness of providing child care.

5. Relationship of four factors to other indices

The caregivers' training and professional network characteristics were examined to determine if they were related to the four RFH factors. The following table shows the index scores for the four factors as a function of the caregiver characteristic. A high average score indicates a high rating on that dimension for those RFHs with the characteristic. A lower score indicates a lower average rating. Only significant differences (p<.05) are shown.

Characteristic	Status	Environment	Caregiver	Child care	Relations
Child referral service	No	-.06	.02	-.06	-.04
	Yes	.07	-.11	.27	.10
Food program	No	.12		-.25	-.16
	Yes	-.09		.08	.03
Minimum standards training	No	.00		-.14	-.08
	Yes	-.13		.30	.11
High school diploma	No	-.44	-.12	-.08	
	Yes	.06	.04	.05	
Child care organization	No			-.07	
	Yes			.39	

Overall, 11 of the 20 possible relationships are in a direction consistent with the assumptions implicit in this analysis--that certain characteristics of the caregiver should be associated with relatively higher ratings of the RFH. In six cases no such significant relationship is found and in three others the relationship is reversed from what was expected.

Membership in a child referral service is associated with relatively low rated caregiver motivation. This may reflect a tendency for caregivers with little or no sense of the business of operating an RFH relying on the child referral service for obtaining clients for their business.

Membership in the food program is associated with RFH environments rated less safe and clean. This may reflect a tendency for those in the lower income ranges to join the food program although there is no data in this study on income and its relation to compliance or these indices of RFHs.

With respect to minimum standards training the data indicates that section of the training relating to the physical environment is not effective.

Every caregiver characteristic is positively associated with relatively high child care skills. The surprise, however, is that child care associations are not significantly related to the ratings of RFH environments, caregiver motivation or relations with outside persons.

Training indices were correlated with the factor scores to determine their relationship. Correlations between the child care factor scores and the caregivers' training in the past two years (.23) and since February 1990 (.20) were significant. The more training the caregiver has taken, the higher rated the caregiver's effective child care practices. None of the other three factors was significantly associated with training. Finally, the caregiver's age was also positively associated with child care practices (-.11) such that the younger caregivers scored higher on this factor.

In general, the assumptions about certain caregiver characteristics promoting compliance are supported by this observational data made by monitors at the conclusion of the monitoring visits. This pattern is especially vivid for the effective child care practices factor which is invariably associated with caregiver characteristics as expected.

IV.COMPLIANCE WITH THE MINIMUM STANDARDS

A. OVERALL COMPLIANCE LEVELS

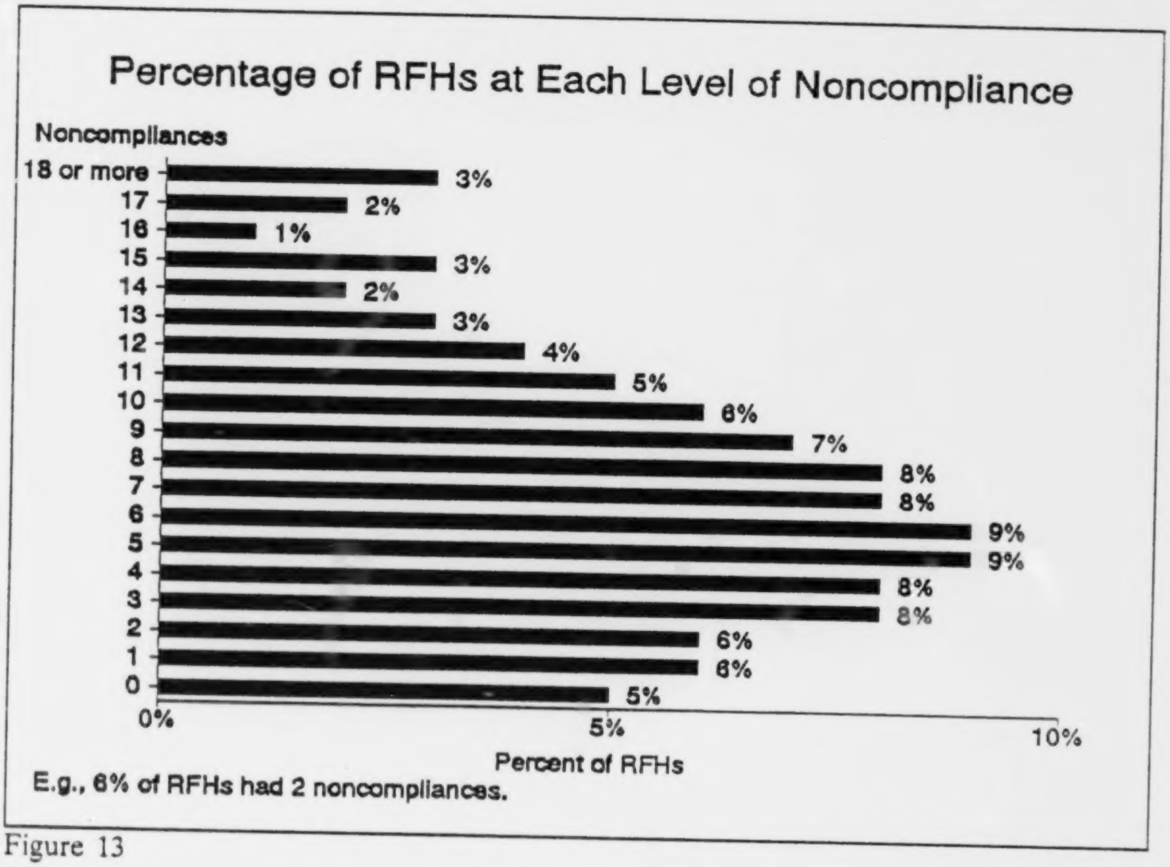


Figure 13

The percentage of RFHs for each level of noncompliance is shown in the accompanying table. As shown, only 5% of the RFHs had no noncompliances. The average overall rate of noncompliance found for RFHs visited during Project CHERISH was 7.1, with about half (51%) of the RFHs having less than 7.00 (median).

B. NONCOMPLIANCE RATES FOR EACH STANDARD

The noncompliance rate for each standard was computed as the number of noncompliances divided by the sum of compliances and noncompliances. A number of standards were not evaluated in every RFH. For example, the standard requiring caregivers under 21 years of age to have certain training was only applicable to those RFHs operated by caregivers under 21. The noncompliance rates reported refer only to the percent noncompliance for those RFHs for which the standard applies. That is, for each standard, the "not applicable" and "not evaluated" categories were not used in computing the noncompliance frequency rates.

1. Standards with over 50% noncompliance

Five standards were found to have noncompliance rates in excess of 50%. The noncompliances for these five standards account for 35% of all noncompliances observed in this study. The standards for which the noncompliance rate exceeded 50% were:

Standard	Noncompliance Rate
Has 40BC (or approved) fire extinguisher	60%
Keeps immunization records of children	58%
Adults in home have completed TB exam, if required	56%
Has all required first aid supplies	54%
Keeps TB test records for children in care	53%

The fire extinguisher standard could be violated by either having no fire extinguisher or having one or more fire extinguishers that were not type 40BC. Fire extinguishers other than type 40BC can meet this standard if written approval had been obtained from the local fire marshall. Eighty-eight providers (4%) had fire extinguishers which were not the required 40BC. These other types were primarily (1A)10BC (n=41), (2A)10BC (n=19), and 5BC (n=4). Seventy-five percent of these providers had written approval for their fire extinguishers. Note that virtually all of the 60% noncompliance rate for this standard stemmed from not having **any** fire extinguisher.

	Fire Extinguisher			
	None	40BC	Non-40BC	Total
Compliance	--	37%	3%	40%
Noncompliance	59%	--	1%	60%

The standard requiring first aid supplies lists seven specific items to be included in the set. Missing items were inventoried by the monitors for those RFHs in violation of the standard. Only 65 caregivers (2% of the sample) were missing all 7 required items. Ninety five percent of providers had at least 3 of the first aid items, 77% had at least 6 of the seven items. The percentage of RFHs missing each item is given below. The most frequently missing items is, by far, syrup of ipecac: About 1 of 2 caregivers (49%) do not have this item in their first aid kit. It appears that noncompliance with this standard is primarily due to not having all required items, particularly syrup of ipecac, in the first aid kit.

First Aid Item	Percent Missing
Syrup of ipecac	49%
Gauze pads	13%
Hydrogen peroxide	11%
Tweezers	9%
Thermometer	9%
Cotton balls	9%
Multi-size bandages	8%

2. Standards with 25% to 49% noncompliance

Seven standards were found with noncompliance rates between 25% and 49%. Combined with the standards with over 50% noncompliance, these twelve standards account for 63% of all noncompliances. Standards found to have noncompliance rates between 25% and 49% were:

Standard	Noncompliance Rate
Keeps all required phone numbers posted near phone	44%
Keeps emergency medical authorization for children	43%
Has current first aid certificate	39%
Has current CPR certificate	33%
Emergency forms taken when children away from RFH	32%
First aid supplies taken when children away from RFH	30%
Keeps required animal vaccinations records for pets	29%

The phone number posting standard lists eight specific phone numbers which must be posted near a phone. When noncompliance was found with this standard, monitors inventoried those numbers which were missing. Only 6% of providers not in compliance with this standard did not list any of the required numbers. Eighty-eight percent had at least 4 of the 8 required phone numbers, 77% had at least 6. The percentage of RFHs missing each required phone number is listed below. About 1 of 3 RFH providers do not list their own phone number and 1 of 4 RFH providers do not list the number of the Texas Department of Human Services (TDHS) office.

Phone Number	Percent Missing	Phone Number	Percent Missing
Own phone number w/ address	30%	Parents	16%
TDHS office	27%	Ambulance/EMS	10%
Child abuse hot line	20%	Fire station	9%
Poison control center	19%	Police/Sheriff	9%

3. Standards with 15% to 24% noncompliance

Nine standards were found with noncompliance rates between 15 and 24 percent. Combined with the twelve standards found to have noncompliance rates of 25% or more, these 21 standards account for 77% of all noncompliances found.

Standard	Noncompliance Rate
Swing sets have lightweight pliable seats	24%
Cleaning supplies stored away from children	22%
Certified water safety adult at pool	22%
Caregiver under 21 years old meets qualification	20%
Practices emergency plans every six months	20%
Home, indoors and outdoors, free of hazards	19%
Sign posted on reporting suspected child abuse	16%
Criminal history forms for other adults in RFH	16%
Space heaters enclosed	15%

The standard governing access to cleaning supplies is paralleled by three other standards governing access to bug sprays, medicines, and other hazardous materials. If combined, so that noncompliance on any one of these four access standards constitutes noncompliance to one comprehensive standard, the noncompliance rate increases slightly to 25%. Other hazardous materials identified include personal grooming supplies such as hair spray (54 cases), poisonous plants, food or fertilizer (8), paints and painting supplies (8), car supplies (6), and gasoline (6).

Twenty-two percent of those individuals who allow children in care to swim at the facility do not have a proper water safety certification. Of those who do have the proper water safety certificate, less than 1 percent had either a lifeguard or life saving certificate. Thus, virtually all caregivers who allow children to swim in their pool and who are in compliance with the standard have a water safety certification.

The general hazards standard allows for citing hazards not directly specified in the standards. Monitors recorded the specifics of the hazard as applicable. The most frequently cited hazard was the see-saw (25%), followed by gliders (7%), accessible tools/lawnmowers (6%), and various debris in the yard such as bricks, pieces of metal and wire (5%).

Hazards were then grouped on the basis of similarity to get an idea of the general problems encountered. Forty-four percent of the hazards were related to *playground type* *equipment* and toys. *Home maintenance* problems such as animal feces, roaches, broken glass, lumber, and general clutter accounted for 40% of the responses. Thirteen percent of these hazards dealt with *childproofing* issues, such as accordion gates, sharp edges, and access to hazardous areas. Three percent of these hazards were related to access to *hazardous items* access to such things as heaters and refrigerators in the yard or guns and knives in the home.

C. LOW NONCOMPLIANCE

No standard was found to have absolute compliance. However, 32% (n=36) of the standards had only 10 instances or less of noncompliance (out of a possible 2813 cases)! Fifty-eight percent of the standards (n=65) had noncompliance rates of 3% or less. Seventy-one percent of the standards (n=80) had noncompliance rates less than 10%. A great majority of the standards are being complied with by most caregivers.

Standards With Less than 10 Noncompliances

1000	THE CAREGIVER AND FAMILY	
	1100	**Caregiver qualifications**
		Caregiver is age 21 or older
		20 clock hours of training obtained per year
		Substitute caregiver must be 18 years or older
		14-17 year olds never left alone with children
	1200	**People in the home**
		No persons in RFH convicted of specified crimes
		No persons in RFH indicted of specified crimes
2000	THE CHILDREN IN CARE	
	2100	The number of children in care
	2200	**Admission requirements**
		No racial discrimination
		No child in care on 24 hour basis longer than 30 days
3000	HEALTH AND SAFETY	
	3100	**Fire prevention, sanitation, and safety**
		Fire prevention
		Central heating units inspected as recommended
		Liquid/gas fuel heater properly vented

Standards With Less than 10 Noncompliances

Sanitation
Approved water supply
Approved sewer system
Running water in home
Caregiver washes hands after using toilet
Caregiver washes hands before eating
Caregiver washes hands before/after handling sick children
Safety
Children kept away from dangerous animals
No dangerous (e.g., shooting) toys in RFH
Appropriate merry go round fall zone
Water safety
No playing near unfenced pool in apartment complex
Adult/child ratio met for wading pool
Adult/child ratio met for swimming pool
Life saving device present near swimming pool
Pool chemicals out of reach of children
Transportation
Children under 2 year in infant carrier/child seat
Shoulder harness not across face or neck
Restraints properly anchored and used correctly
Children do not ride in back of pickup truck
3200 Nutrition
3300 Telephone
3400 Accidents and illnesses
Parents notified of sick/injured child at once
Emergency attention obtained for serious injuries
4000 CHILD CARE IN THE REGISTERED FAMILY HOME
4100 Supervision
4200 Abuse or neglect of children in care
No abuse/neglect of children in RFH
4300 Activities
Both active and quiet play available for children
Infants allowed outside cribs
4400 Discipline
Signed permission for spanking children
Open hand used to spank children
Spanking limited to buttocks

D. NONCOMPLIANCE BY STANDARDS SECTION

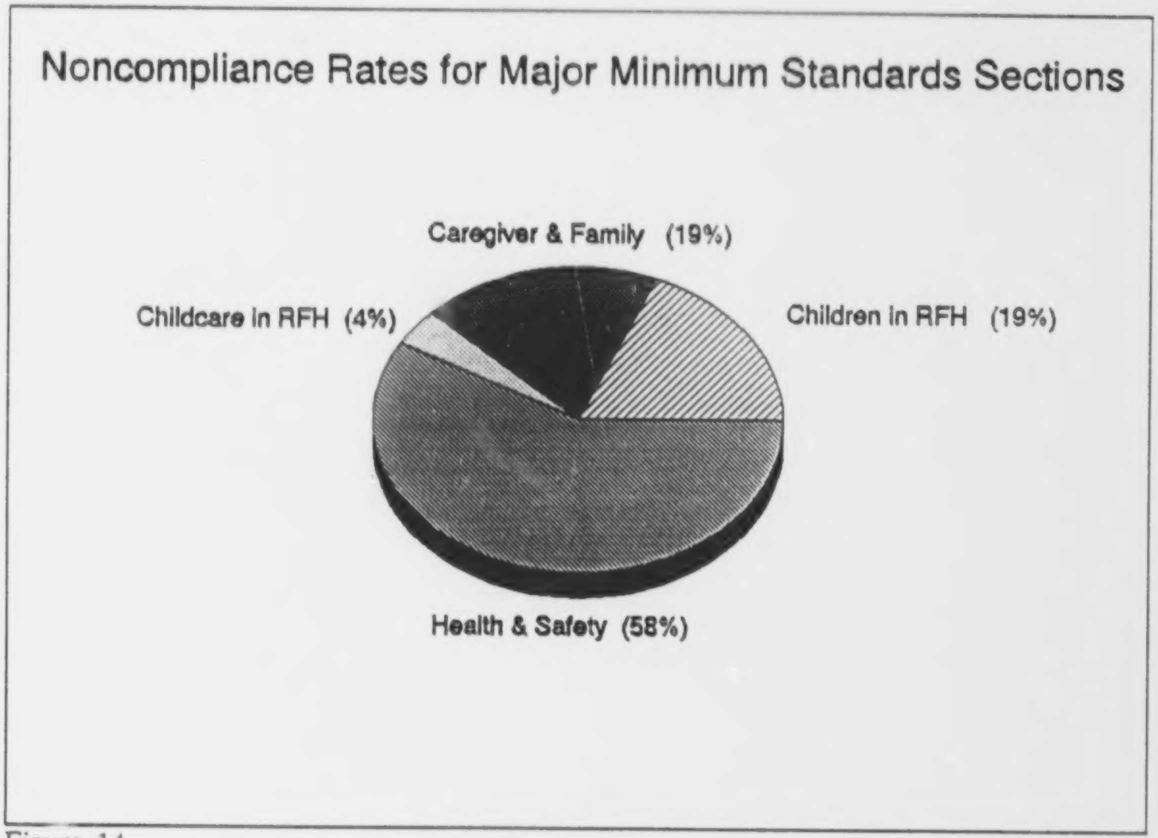

Noncompliance Rates for Major Minimum Standards Sections

Figure 14

The relative noncompliance rate for each of the four major standards sections are shown in the accompanying graph. Health and Safety accounts for well over half the noncompliances found, with the Caregiver and Family and Children in the RFH sections each accounting for 19% of the noncompliances. The Child Care in the RFH standards were found to have almost universal compliance.

The relative noncompliance rate for each of the 12 subsections provides more specifics.

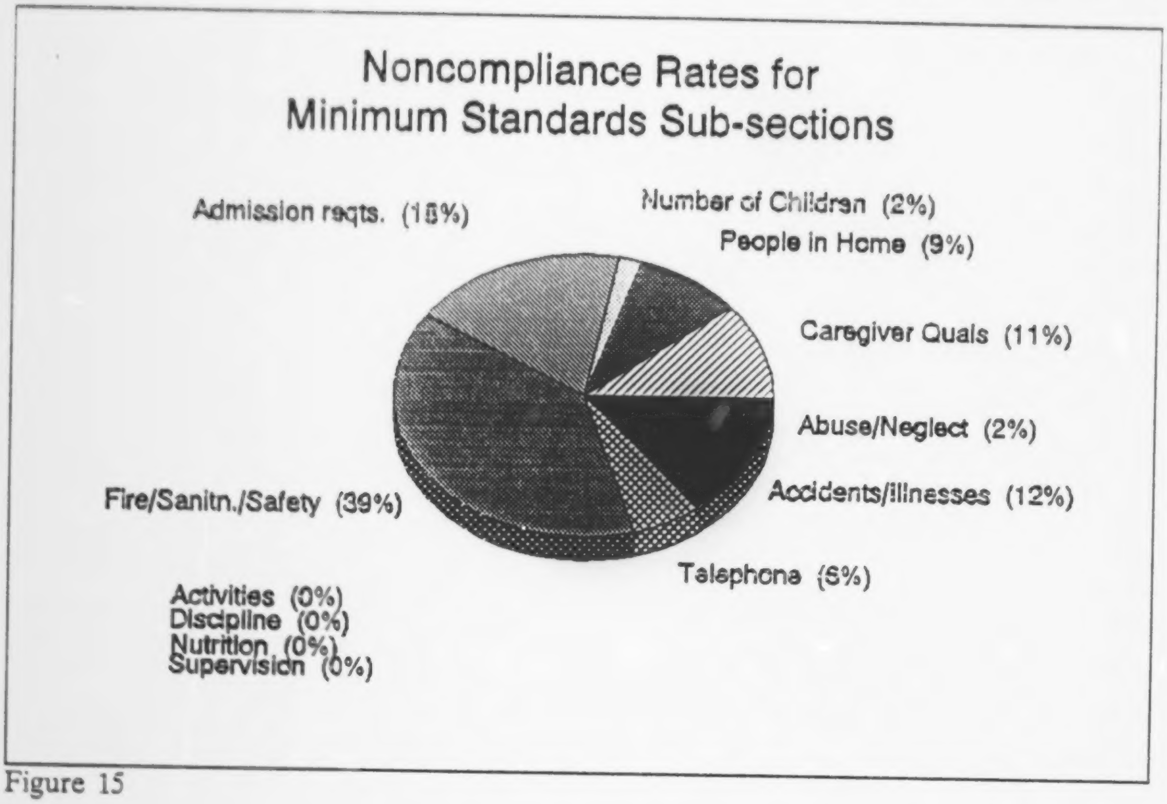


Figure 15

For the Caregiver and Family section there is roughly an equal distribution among noncompliance concerning the caregiver and noncompliance concerning the family (and other people in the house).

Ninety percent of the noncompliances in the Children in the RFH section are due to noncompliance with admission requirements.

Fire, sanitation, and safety, accounts for two-thirds of the noncompliances in the Health and Safety section of the minimum standards, followed by accidents and illnesses with 21% and telephone with 10% of the noncompliances in that section.

Finally, noncompliance with standards concerning abuse and neglect appear to account for nearly all the noncompliance in the Child care in the RFH section of the standards.

The noncompliance rates for each of the minimum standards sections may be more a function of the number of standards evaluated in each section--a section with more standards is likely, by chance, to have more observed noncompliances than a section with fewer standards. Consider the 4 major sections of the minimum standards, the observed percentage of noncompliance, the percentage of standards in that section, and the difference in the following table.

Standards Section	Percent of Standards	Percent Noncompliance	Difference
Caregiver & Family	14	20	6
The Children in Care	7	20	13
Health and Safety	64	57	(7)
Child Care in the RFH	15	3	(12)

From this vantage point the children in care section, which has the fewest standards of any section, shows the highest difference between noncompliance and the percent of standards. The percent of noncompliance is almost 3 times as much as the percent of standards in this section. Child care in the RFH is the most complied with section. Although it accounts for 15% of the standards it only accounts for 3% of the noncompliances.

This same analysis was conducted using noncompliance rates for the subsections. Those subsections with differences of plus or minus 5 are recorded below.

Standards Subsection	Percent of Standards	Percent Noncompliance	Difference
Admission requirements	6	18	12
Accidents/illness	7	12	5
Water activities	9	1	(8)
Sanitation	12	3	(9)

The subsections on admission requirements and accidents and illnesses appear to account for more noncompliance than would be expected given the percentage of standards in those sections. Conversely, water activities and sanitation are two sections in which noncompliance is below what would be expected given the number of standards in those sections.

Otherwise, no sections of the standards appear to be problematic in terms of noncompliance. In fact, the correlation between the percent of noncompliance for each section and the percent of standards in that section relative to all standards is .59 and it is statistically significant.

E. FACTORS INCREASING COMPLIANCE WITH THE STANDARDS

A fundamental assumption in the creation of the minimum standards was that increasing the qualifications of the caregiver would result in more compliance. Caregiver competencies fall into two broad classes--levels of training mandated by the minimum standards and elective participation in professional child care organization or networking characteristics.

1. Level of training

The levels of training specified by the standards are high school diploma/GED, RFH orientation for newly registered family homes, and twenty clock hours training.

Every new RFH provider must have a high school diploma/GED or meet exception criteria to show a comparable competency level. Those already registered are not required to have a high school diploma/GED if they do not already. We thus have the appropriate populations to test whether the high school diploma makes a difference in the compliance rate. As the table below shows, those providers with high school diplomas or GEDs average about 2 noncompliances less than those without one. This difference is statistically significant.

Level of Training	Yes	No
Has high school diploma	6.9	9.1
Has attended minimum standards training	6.5	8.3

A 6-hour RFH orientation is also required of all newly registered family home providers. Those already registered were given the option of attending a department sponsored minimum standards training which covered the new minimum standards and, in general, paralleled the orientation given to new providers. A comparison of those who had and had not completed the minimum standards training with respect to their levels of noncompliance should be comparable with what is expected with the RFH orientation. As the above table shows, those providers who participated in the minimum standards training averaged two noncompliances less than those who had not participated. This difference is also statistically significant.

Another method to increase caregiver competency was to mandate 20 training hours per year. The new minimum standards went into effect at the same time of this study and thus the 20 hours of training was not evaluated as a minimum standard in this study. Caregivers were asked, however, how much training they had received in child care related topics over the past two years and since February 1990. These indices of training hours were then correlated with the noncompliance rate to determine if training hours were directly related to noncompliance.

Both training indices were significantly correlated with noncompliance: -.31 and -.29 for training obtained in the past two years and since February 1990, respectively. The more hours of training, the more compliance with minimum standards.

2. Elective activities

Professional networking is also expected to be associated with lower levels of noncompliance. Child care associations provide caregivers the opportunity to learn from each other in informal settings, formal association functions, and by sponsoring training. Food programs provide various levels of training, often in areas other than nutrition. Finally, child referral services sometimes offer provider training in various aspects of RFHs.

Elective Activities	Yes	No
Is child care association member	4.7	7.9
Is child referral service member	5.8	7.9

As shown in the above table, both child care association membership and child referral service membership are associated with fewer noncompliances. There is an average of about 2 noncompliances less than providers not claiming membership in these activities. Membership in a food program does not significantly impact the level of noncompliance.

Caregiver competency, both in level of education and in some elective activities, is associated with more compliance with the minimum standards.

3. Combinations of training and elective activities

The requirement for a high school diploma in the minimum standards was created to establish a basic level of competency for all caregivers. It has been shown that high school graduates are more in compliance with the standards, as are those in elective professional organizations and programs. Does the required high school diploma provide a level of competency equal to that reflected in elective activities? The number of noncompliances was computed for the elective groups and activities for those with and without a high school diploma. (In this case the minimum standards training was treated as an elective activity.) The table below shows the results.

Elective Activity	High School Diploma/GED	
	Yes	No
Child Care Association		
Member	4.6	5.8
Non-member	7.4	9.4
Child Referral Service		
Member	5.8	6.0
Non-member	7.4	9.5
Food Program		
Participant	6.8	9.2
Non-participant	7.3	8.6
Minimum Standards Training		
Attended	5.7	9.2
Not attended	8.2	9.4

Again, the level of noncompliance for members, participants, and attenders is less than for those who are not. For those who are not participating in these elective activities, however, lower noncompliance is seen for those with a high school diploma compared to those without a high school diploma. Also, for those who participate in child care associations, food programs and the minimum standards training, but not child referral services, having a high school diploma is associated with less noncompliance than for those who do not.

The high school diploma is, however, only a baseline. For every elective activity except child referral services, the *combination* of high school diploma and participation in an elective activity results in the lowest level of noncompliance and/or the having *neither* the diploma nor the elective activity results in the highest level of noncompliance. This relationship is statistically significant ($p<.05$) for each characteristic shown except for food program membership which is marginally significant ($p<.08$).

4. Predicting noncompliance with level of training and elective activities

A regression analysis was performed to determine the best predictors of noncompliance from the required and elective competency indices. This analysis used the stepwise method of predictor entry into the equation so that the strongest statistical predictor of noncompliance is identified first and other predictors that add significantly more than the predictive power of previously selected predictors are sequentially included. The significant ($p<.001$) results are given in the following table.

Predictor	Multiple R	R-Square	F
Hours of training since February 1990	.301	.09	236.67
High school diploma	.369	.14	186.41
Membership in child care organization	.416	.17	165.12
Hours of training in past two years	.426	.18	131.57
Membership in a food program	.429	.18	106.72

The results indicate that the training since February 1990 provides a baseline of compliance which improves with each additional variable--high school diploma, membership in a child care organization, more training, and membership in a food program. Membership in a child referral service does not contribute to the predictive power of these variables.

The evidence converges on these conclusions. The caregiver competencies required in the minimum standards provide a basic level of compliance higher than that obtained by those providers not having demonstrated those competencies. Moreover, elective professional activities are also associated with increased compliance. Perhaps most important, elective professional activities are associated with increased compliance beyond the level found for those required by the minimum standards.

5. Noncompliance and facility variables

Several other predictors of noncompliance having to do with the RFH facility were tested; the type of home (apartment, mobile home, etc.), its location (urban, rural, suburban), the cleanliness and level of safety of the neighborhood (as rated by the monitor) and, the level of traffic near the RFH.

Significant differences ($p<.05$) in noncompliance were found as a function of the type of RFH structure as shown:

Type of structure	Average Number of Noncompliances
Single family residence	7.1
Mobile home	7.2
Apartment	7.9
Duplex/multiple family	9.3

Duplexes or multiple family units were the least compliant facilities.

Significant differences (p<.05) were also found for the location of the RFH. RFHs in suburban areas had much less noncompliance (6.3) than those in rural (8.0) and urban (8.4) settings.

Monitor ratings of the neighborhoods in which RFHs are located revealed significant differences (p<.05) in noncompliance within the RFH.

Cleanliness of Neighborhood	Avg. Noncompliance	Level of Safety for Children	Avg. Noncompliance
Well kept	5.4	Very high risk	7.7
Average	7.0	High risk	10.9
Some deterioration	8.7	Moderate risk	8.6
Poorly kept	8.9	Low risk	6.2

With respect to the general cleanliness of the neighborhood, the cleaner, the less noncompliance. The level of safety for children shows a surprising drop in noncompliance for those RFHs in a neighborhood rated as a very high risk. Perhaps the high risk of the neighborhood provides a contrast which motivates the provider to comply with the standards.

With respect to the level of traffic near the RFH, the farther away the facility was from a heavy use street, the fewer noncompliances were found.

Proximity to Heavy Use Street	Noncompliances
Borders	7.9
Within 1 block	7.3
Within 2 blocks	7.5
More than 3 blocks	6.9

In summary, RFHs in urban and rural areas, RFHs housed in multi-family units (not apartments), bordering heavy use streets, in poorly kept or high safety risk neighborhoods, showed significantly more noncompliance.

6. Predicting noncompliance with facility variables

Stepwise regression analysis was performed on these facility variables to determine the best predictors of noncompliance. The significant results ($p < .000$) are shown below.

Predictor	Multiple R	R-Square	F
Cleanliness of neighborhood	.254	.06	179.40
Suburban location	.289	.08	118.83
Safety of neighborhood	.312	.10	93.82
Mobile home	.318	.10	73.13

The most significant facility predictor of compliance is the rated cleanliness of the neighborhood in which it is located. A suburban location and a clean neighborhood will increase compliance beyond that observed in a clean neighborhood alone. A safe neighborhood increases compliance even more. Finally, a mobile home in a clean, suburban, and safe neighborhood has the strongest association with compliance.

7. Noncompliance and RFH factors

To examine the relationship between the four RFH factors and noncompliance, factor scores were computed for each RFH reflecting its standing on each factor. These RFH factor scores were then correlated with the number of noncompliances for each subsection and with the total number of noncompliances. A negative correlation indicates that a high score on that factor is associated with low noncompliance. A positive correlation indicates that a high score on the factor is associated with high noncompliance. Only significant results ($p < .01$) are shown in the table that follows.

Standards Subsection	Environment	Caregiver	Child care	Relations
The Caregiver and Family	-.08	-.05	-.20	-.05
Caregiver qualifications	-.06	<>	-.21	-.05
People in the home	-.06	-.16	<>	<>
The Children in Care	-.12	-.05	-.08	.05
Number of children in care	<>	<>	-.07	.06
Admission requirements	-.14	-.06	-.07	<>
Health and Safety	-.23	.10	-.18	<>
General hazards	-.15	.06	-.06	<>
Fire prevention	-.17	.10	-.12	<>
Sanitation	<>	.06	<>	.07
Safety	-.20	<>	-.07	-.05
Water safety	<>	<>	<>	<>
Transportation	<>	<>	<>	<>
Forms & supplies	-.05	.05	-.11	-.04
Nutrition	<>	.06	<>	<>
Telephone	-.12	<>	-.14	<>
Accidents & illnesses	-.14	.10	-.16	<>
Child Care in the RFH	-.11	<>	-.10	<>
Supervision	<>	<>	<>	.06
Abuse & neglect	-.10	<>	-.14	-.07
Activities	-.11	<>	<>	.05
Discipline	.05	-.04	-.06	.06
Total	-.22	0	-.20	<>

The environment and child care factors show a highly similar pattern of association with the minimum standards subsections. In general, the RFH home rated clean and safe and the RFH provider using effective child care practices have fewer noncompliances. The major differences between these two factors is that the child care factor is more strongly associated with low noncompliance in subsections in *The Caregiver and Family* section of the standards while the environment factor is somewhat more associated with low noncompliance in the *The Children in Care* section.

The relations factor shows a number of positive correlations with various subsections of the minimum standards, particularly the *Children in Care* and *Child Care in the RFH* sections. The more adept caregivers are at handling outside interference by others, the more likely they are to have more children than allowed and the more likely they are to be in noncompliance with the *Supervision*, *Activities*, and *Discipline* standards.

The caregiver factor has all positive correlations with the number of noncompliances for the subsections in the *Health and Safety* section of the standards. The more cooperative and professional the caregiver, the more likely she will have noncompliances in this section. This may reflect the caregiver's response to noncompliance--she is eager to correct the ones that are found and shows it.

Nonsignificant correlations between the caregiver and relations factors and the total number of noncompliances indicate that the monitors were not influenced in their standard by standard assessment of the RFH by either the caregiver's motivation, or her ability to handle outside relations. That is, the data show no bias in noncompliance rates based on the provider's perceived motivation or her ability to effectively balance child care and the demands of the monitoring visit. The significant correlations between the factor scores and the total number of noncompliances suggest that monitors focused exclusively on aspects of the environment and the child care in the RFH that are covered by the minimum standards.

8. Predicting noncompliance with four RFH factors

The four RFH factors--environment, caregiver, child care, and relations--were used as predictors of noncompliance in a stepwise regression analysis. The significant results ($p<.001$) are shown below.

Predictor	Multiple R	R-Square	F
Environment	.22	.05	142.68
Child care	.39	.15	255.83
Relations	.54	.29	393.85
Caregiver	.54	.29	302.08

The most predictive factor of the four is the RFH environment. Adding the child care factor increases the predictive power considerably and adding the relations factor increases the predictive power even more. Although the contribution of the caregiver factor to the equation is significant, it is relatively small.

No single aspect accounts for the bulk of noncompliances, rather, environment, child care, and relations, in combination, account for most of the noncompliance variance that can be accounted for. The motivation of the caregiver contributes relatively little, having no direct association with noncompliance and contributing in a minor way when combined with the other three factors in predicting noncompliance.

F. PERCEIVED DIFFICULTIES IN MEETING THE STANDARDS

1. Cited difficulties

Caregivers were asked what difficulties they had in meeting the new minimum standards. Data from the pilot study revealed a set of 11 common responses which provided the response alternatives for the main study. The monitor coded the caregiver's response(s) noting both the difficulty and the relevant section of the standards.

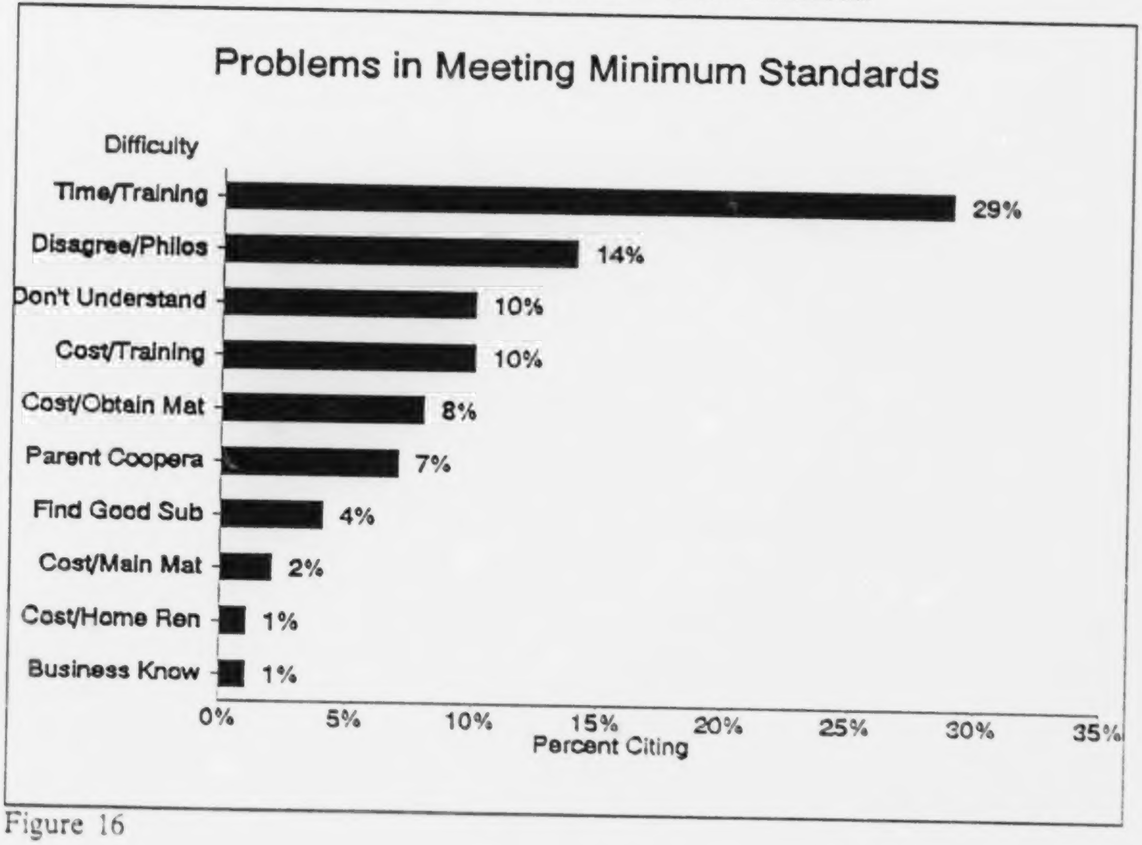
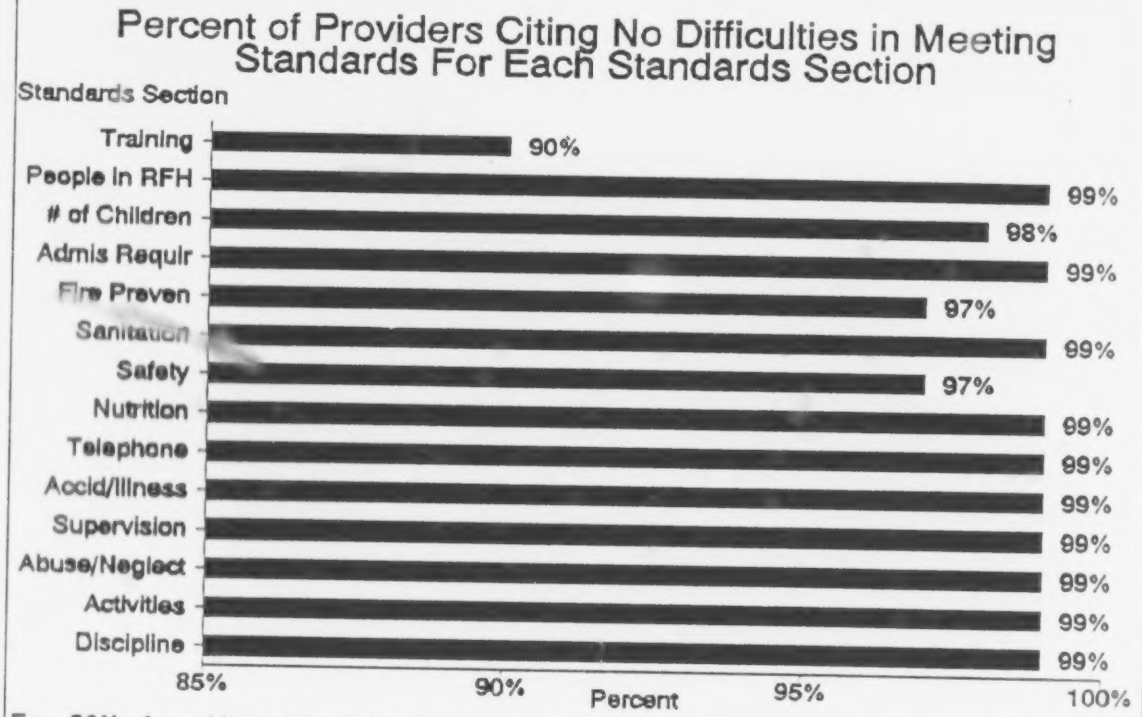


Figure 16

Thirty-two percent of the caregivers cited at least one difficulty in complying with the standards. Of those who cited problems, 29% cited the problem of finding time to attend the required training. Many (14%) cited particular standards with which they disagreed with the philosophy, for example, the prohibition against the use of spanking for disciplining children under 5 years old. Some (10%) did not understand the standard and others cited the costs involved in training (10%) or obtaining the necessary materials (8%).



E.g., 90% of providers don't find it difficult to meet the training requirement

Figure 17

Thirteen percent cited some other problem, almost all of which were variations on the above categories. Several unique difficulties were identified: a physical inability to learn or perform CPR due to obesity, problems with a husband who refuses to stop smoking, and a loss of income due to limits on the number of children.

The percent of providers citing difficulties in complying with standards for each standards subsection is also shown. Training is the most problematic standards section with about 1 of 10 caregivers citing difficulties. For all other sections, less than 3% of the caregivers cite any difficulties. This probably reflects the monitors' ability to provide inexpensive and suitable means for complying with the standards that are found to be in noncompliance.

An examination of difficulties for each specific section is shown in the accompanying table. The numbers in each row refer to the percentage of respondents citing that particular difficulty for that specific standards section. Thus, for example, 52% of those citing problems in complying with the training section of the standards, cited finding time. In every section but training and fire prevention, the most frequently cited difficulty is a lack of understanding.

Section	Difficulty	Difficulty	Difficulty
Training	Finding time (52%)	Cost (18%)	
People in RFH	Lack understanding (44%)	Find substitute (18%)	Disagree philosophy (12%)
Number of children	Lack understanding (33%)	Disagree philosophy (25%)	
Admission requirements	Lack understanding (60%)	Knowledge of business practices (17%)	
Fire prevention	Cost to obtain materials (40%)	Lack understanding (26%)	Cost to maintain materials (12%)
Sanitation	Lack understanding (66%)	Cost to obtain materials (9%)	
Safety	Lack understanding (26%)	Cost to obtain materials (26%)	
Nutrition	Lack understanding (85%)		

Section	Difficulty	Difficulty	Difficulty
Phone	Lack understanding (93%)		
Accidents and illnesses	Lack understanding (46%)	Find substitute (43%)	
Supervision	Lack understanding (66%)	Find substitute (13%)	
Abuse and neglect	Lack understanding (92%)		
Activities	Lack understanding (52%)	Cost to obtain materials (24%)	Cost to maintain materials (13%)
Discipline	Lack understanding (49%)	Disagree with philosophy (17%)	

The lack of understanding was generally in regard to understanding the rationale for a standard. For example, caregivers often did not have their own phone number and address by the phone thinking that if there was an emergency, they knew their own number and where they lived. When monitors explained that this precaution was in case the emergency involved the caregiver, that this information was in case someone else had to summon emergency help, caregivers were able to see the need for this standard and saw a necessity in complying. Monitors spent much of their time helping the provider see the rationale for the standard to help the caregiver understand the necessity in complying.

2. General perceptions

The anonymous caregiver questionnaire had two general questions about difficulties in complying with the minimum standards. The questions and the responses are presented in the table that follows.

Questionnaire Item	Not	Not Very	Moderately	Very	Especially
How easy will it be for you to comply with the minimum standards?	1	2	15	47	35
How reasonable will the costs be for you to comply with the minimum standards?	2	6	36	36	21

Generally, providers say complying with the minimum standards, even from a financial perspective, is easy.

V. ANALYSIS OF THE MINIMUM STANDARDS

The minimum standards were evaluated using three different approaches. First, each standard was rated on several dimensions, including its observed frequency of noncompliance. Second, general ratings about the quality of the standards were made by caregivers of monitored facilities responding to an anonymous questionnaire. Third, both monitors and caregivers were requested to articulate areas of safety and health concerns they think should be, but currently are not, addressed by the minimum standards.

A. DIMENSIONAL RATINGS OF THE MINIMUM STANDARDS

Each standard was assessed on four dimensions: 1) the perceived **specificity** of what constituted noncompliance relative to other standards, 2) the **time** it took to establish compliance relative to other standards, 3) the frequency with which establishing (non)compliance was from direct **observation**, and 4) the frequency with which the monitor provided, or was asked to provide at a later time, technical **consultation** about how to comply with the standard. The ratings on these dimensions--time, specificity, observability, and consultation--were then compared with the observed frequency of noncompliance, to discover how these dimensions impact noncompliance.

1. Specificity

For the specificity ratings, the monitors were asked to rate each standard on the degree to which noncompliance was clearly specified in the standard relative to the other standards. The score for each standard was the average of the ratings across the 14 monitors who used a 7-point rating scale anchored by "not clear" and "very clear." Monitors selected the best exemplar of not clear and the best exemplar for very clear to use as anchors. They then rated each of the remaining standards. This data was collected in the ninth month of the project ensuring a wide breadth of experience from which to make the judgments.

The mean specificity rating was 5.77, well above the midpoint. Those standards whose ratings were significantly below this mean (1.96 standard deviations) were identified as low specificity items. These standards, in order of decreasing specificity, were (with averages in parentheses):

Low Specificity Items

1. Supervision appropriate to the age of the children, individual differences and abilities, layout of the house and play area (floor plan, arrangement, intercoms, established boundaries), and neighborhood circumstances, hazards, and risks. (4.19)
2. Electrical wiring system, fuses or circuit breakers, and cords for electrical appliances and lighting fixtures are in safe condition. (4.06)
3. No open flame space heaters. (3.94)
4. Sufficient toys and equipment available that are appropriate for the developmental stages of children in care. (3.94)
5. Liquid or gas fuel heaters are vented properly to the outside. (3.81)
6. Central heating units inspected by qualified technician as recommended by the manufacturer. (3.75)
7. Home, indoors and out, free of hazards and otherwise safe and healthy for children. (3.43)

Those standards with an average specificity rating of 6.80 or more were identified as high specificity items. These standards, in order of increasing specificity, were:

High Specificity Items

1. Caregiver must have a high school diploma or Texas Certificate of High School Equivalency (GED) or similar credential. (6.81)
2. Ensure that animals on the premises have been vaccinated according to a licensed veterinarian's recommendation. Keep documentation of the vaccinations and recommendations. (6.81)
3. Must have a working telephone. (6.81)
4. Provide running water in the home. (6.87)
5. Must be at least 21 years old. (6.88)
6. Provide at least one flush toilet inside the home. (6.88)
7. Provide at least one lavatory inside the home. (6.88)

2. Time

For the time ratings, the monitors were asked to rate each standard on the relative amount of time it took them to establish (non)compliance using a 7-point scale anchored by the "least amount of time" and the "most amount of time." Monitors selected the best exemplar of least amount of time and the best exemplar for most amount of time to use as anchors. They then rated each of the remaining standards. Each standard's score was the average of the ratings across the 14 monitors. This data was collected in the tenth month of the study.

The average time rating across all the standards was 3.24, close to the midpoint of 4 on the scale. Those standards that were significantly higher than this mean (1.96 standard deviations) were identified. Those standards taking the most amount of time according to this criterion were, in order of decreasing time:

High Time Items

1. Caregiver must obtain and keep current immunization records for each child in the home including her own children's records. (6.15)
2. Home, indoors and out, free of hazards and otherwise safe and healthy for children. (6.08)
3. Caregiver must obtain and keep emergency medical authorization for each child. (5.54)

Two other standards were not significantly different from the average but deserve mention:

4. Cleaning supplies kept where children cannot reach them. (5.08)
5. Bug sprays kept where children cannot reach them. (5.08)

Those standards with average ratings of 1.75 or less were identified as low time standards. These standards were, in order of decreasing time:

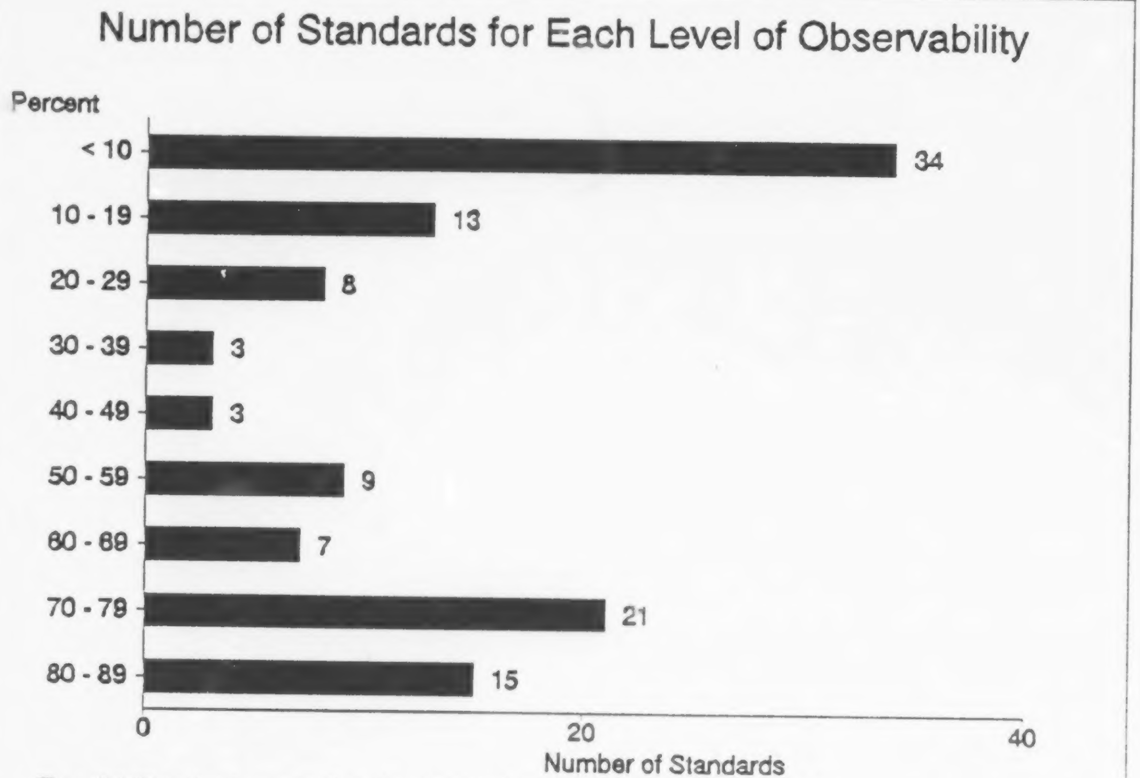
Low Time Items

1. At least one flush toilet inside the home. (1.62)
2. At least one lavatory inside the home. (1.62)
3. Must have a working telephone. (1.38)
4. Use either a public water supply or a private well that is approved by local health authorities or the Texas Department of Health. (1.31)
5. Use either a public sewage disposal system or a private system that is approved by local health authorities or the Texas Department of Health. (1.31)
6. Provide running water in the home. (1.23)

3. Observability of (non)compliance

As the monitors checked each standard for compliance they indicated with a check mark whether compliance was established by direct observation and/or discussion with the caregiver. The frequency of each of the resulting three categories--observation, discussion, or both--was computed for each standard.

Analyses showed that the frequency with which both discussion and observation were both checked was very low--all but two standards had frequencies of less than 20%. In addition, the correlation between the frequency of direct observation and the frequency of discussion was highly negative (-.85). Thus, monitors appear to evaluate most standards with **either** direct observation or discussion.



E.g., 34 Standards were directly observed in less than 10% of the visits.

Figure 18

The standards were then examined to determine how many were being evaluated with direct observation. The table shows the percentage of standards at each level of observability. Thus, for example, 31% of the standards had direct observation checked over 70% of the time and 30% of the standards had direct observation checked less than 10% of the time.

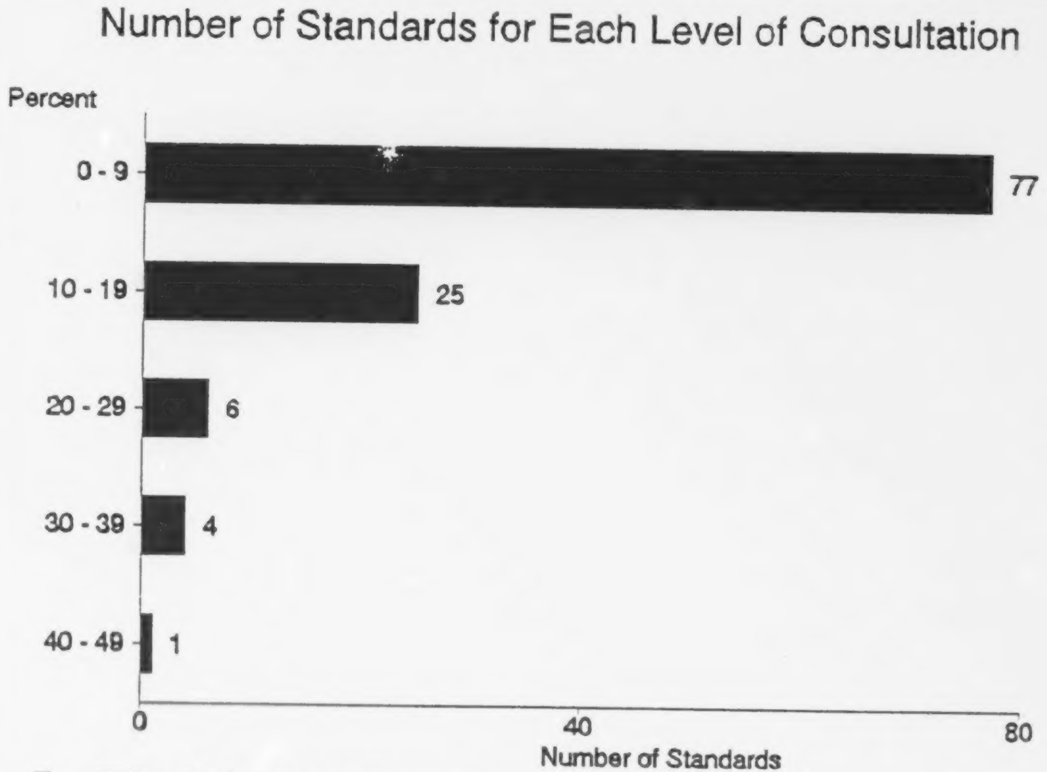
The distribution chart also shows that the minimum standards includes both standards for which (non)compliance is observable and standards for which (non)compliance is established through discussion with the caregiver, with slightly more of the latter than the former.

4. Technical consultation

The monitoring visit was, in part, a vehicle for providing information to help caregivers meet and exceed standards. As each standard was assessed for compliance the monitor would also explain the standard, its rationale, and ways to meet and exceed it. Some standards required more information than others. When the standard appeared to confuse the caregiver after the basic information about it was provided, or the monitor thought it best to provide more clarifying information, the monitor provided what is termed "technical consultation." The monitor indicated for each standard whether technical consultation was provided during the visit or requested for a later time.

The frequency of each category of technical consultation--provided, requested, or both--was computed for each standard. Analysis of the requested consultation revealed a mean of .00 for all but 2 standards which had means of .01. This appears to reflect the work practices of the monitors, each of whom carries in the car an RFH information box or two packed full of resource information including articles, lists of helpful organizations, best practices information, training resources, and more. They have almost all the materials they need to provide technical consultation at the home when it is requested or otherwise seems necessary.

The technical consultation information was recomputed combining the provided and requested categories to make a general technical consultation required category and the frequency of required consultation for each standard was computed. The table shows that most standards were self-explanatory, easily understood, and/or required very little technical consultation--88% of the standards required consultation less than 20% of the time. The lone stand-out at .46 was the standard on the 40BC fire extinguisher. It is likely that technical consultation on this standard was in telling providers the procedure for getting the local fire official to approve a less expensive but adequate fire extinguisher and then requesting a waiver from TDHS.



E.g., 77 Standards required consultation in < 10% of the visits.

Figure 19

B. CORRELATION OF DIMENSIONS

The following table shows the correlations between specificity and time ratings and the frequencies for direct observation, required technical consultation and noncompliance.

Correlations Between Standards Indices

	Specificity	Time	Observation	Consultation
Time	-.17			
Direct Observation	-.06	.28*		
Technical Consultation	.17	.62*	.13*	
Noncompliance	.17	.45*	.30*	.72*

*p<.05.

The first observation is that the specificity of the standard is not related to the time it takes to evaluate compliance, whether (non)compliance is directly observable, how much technical consultation is required, or noncompliance. Thus, although some standards are less clear about what constitutes (non)compliance this alone does not appear to impact the evaluation of the standard, nor does this result in more noncompliance.

Across the bottom row, the frequency of noncompliance is correlated significantly with time, observation, and consultation. The largest correlation (.72) is between technical consultation required and noncompliance. Monitors indicate more consultation is required on standards which have high noncompliance rates and less consultation is required on standards with low compliance rates. Standards for which frequent noncompliance is found also tend to be ones requiring more time (.45) to assess and ones which are evaluated with direct observation (.30). Standards with less noncompliance take less time to evaluate and tend to be less directly observable.

The time rating for each standard appears to be a function of whether the standard is in frequent noncompliance, requires consultation (.62) and is evaluated with direct observation (.28).

C. RATINGS BY CAREGIVERS

After evaluating the RFH on the minimum standards, monitors asked each caregiver this question: "Do the RFH standards promote the health and safety of children?" Virtually every caregiver in our sample answered "Yes." (Eleven providers responded "No".)

Eighty-five percent of respondents indicated that they had received a copy of the July 1990 revised standards before the monitoring visit. In response to the question "How familiar are you with the standards?" only 5% responded with "Not very" or "Not."

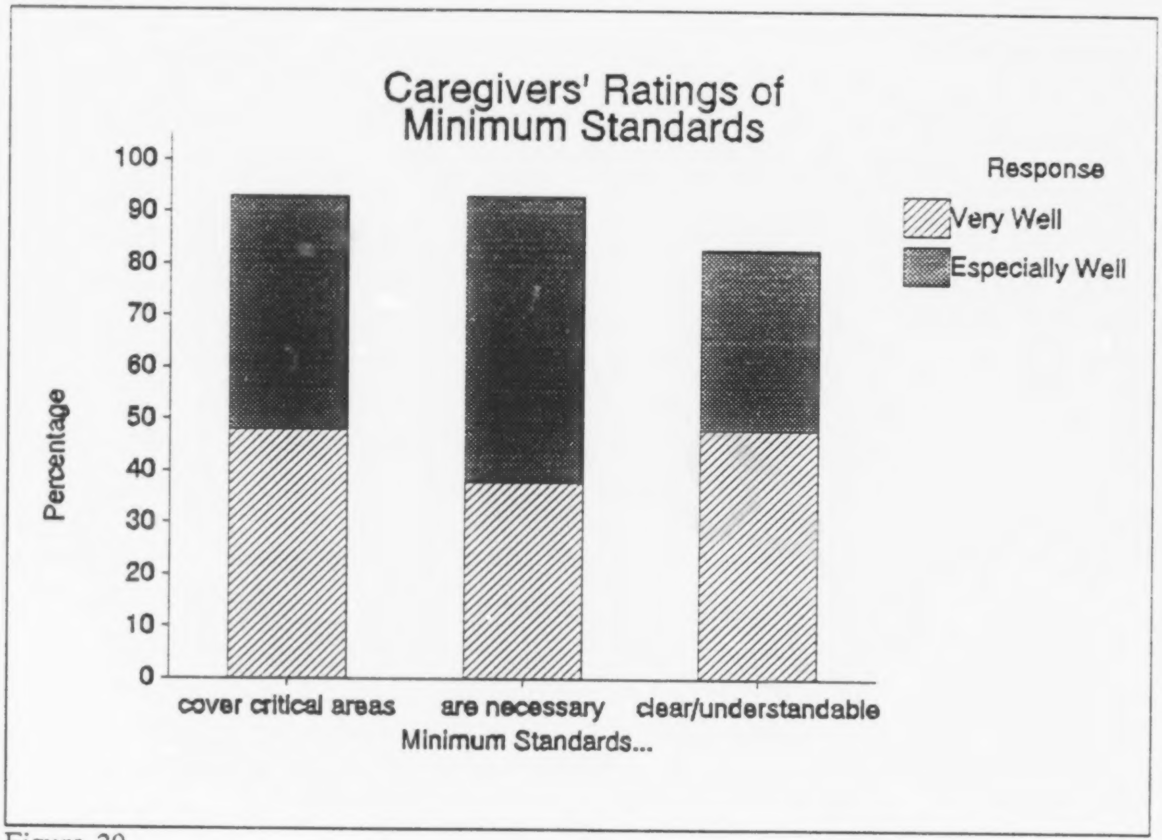


Figure 20

Caregivers were asked three questions about the standards:

1. How well do the minimum standards cover the critical areas of safety and health of children?
2. How necessary are the minimum standards for the safety and health of children?
3. How clear and understandable are the minimum standards?

Caregivers responded favorably to these questions as shown in accompanying table. Only 2% or less of the caregivers answered negatively (Not very, Not) to these questions.

D. UNIDENTIFIED AREAS OF RISK

Both monitors and caregivers were asked to identify areas of risk they believed should be but were not covered by the minimum standards. Three percent of providers (n=87) responded with 48 suggestions. Fourteen said that there should be more RFH inspections, 7 others said that each RFH should be inspected before being allowed to register. Eight indicated that yards should be fenced and 5 cited uncovered electrical outlets as areas of risk. Other responses included:

1. Who picks up children (including inebriated parent) (4)
2. More specific cleanliness standards (3)
3. Specific parental responsibilities spelled out (2)
4. Register homes with less than 3 children (2)
5. More specific outside equipment standards (2)
6. More training needed (2)
7. Staff/child ratio should be lower (2)
8. AIDS testing (2)
9. Fire exit windows should be low to floor
10. Maximum age for caregivers
11. Doors locked during operation
12. Locked, fenced swimming pools
13. Yearly TB test; yearly criminal history checks
14. Caregiver training in recognizing child abuse/neglect
15. Poisonous plant standards
16. Space requirements both inside and out
17. Specific guns/ammunition standards
18. Kitchen utensil protection
19. Sharp corners padded
20. Covered toilet seats.

Monitors also identified areas of risk not covered adequately by the minimum standards. The response rate to this item was 11% and responses identified very specific risks. These fell into general categories of the facility, environment, the caregiver, and caregiver practices.

Areas of risk noted for the facility were having burglar bars on windows, lack-of-space problems (1 bedroom facility with 12 children in care), defining fire exits for upstairs apartments, hazards involved with having a two or more story house, hazards created from ongoing remodeling or renovations to the facility, exposed or accessible water heaters, and hazards created when the caregiver or other adult resident operates another business (e.g., beauty shop, ironing service, arts and crafts, junkyard) at or adjacent to the facility.

Inside the facility, hazards cited were guns and ammunition storage, gasoline storage, and yard tools, particularly lawn mowers.

Several hazards were noted about the RFH environment. General neighborhood conditions cited were vagrants loitering nearby, poorly kept apartment complex, high crime neighborhoods, and proximity to railroad tracks. In some cases, fences seemed to be necessary to ensure the safety of the children. The risks associated with jacuzzis and tree houses (and tree hanging swings) were also cited along with requests for more specific guidelines or standards about them. Barbecue grills were also cited as potential risks. Finally, the issue of risk associated with farm animals such as pigs and chickens was raised.

Concern was raised about the ability of the caregiver to care for children. Specifically, there were perceived risks associated with the physical (dis)ability of the caregiver (at least one caregiver said she was legally blind), the maximum age of the caregiver, and the caregiver's ability to speak English. This latter concern was raised with respect to both communicating with English-only speaking children in care and the ability of the caregiver to summon emergency assistance on the phone. The caregiver's level of personal hygiene was also mentioned as a possible source of risk for children.

Risk issues cited about caregiver practices included defining criteria for general clutter and filth (including odor). Other practices that may involve risk that need attention have to do with the use of electrical appliances: electrical appliances such as hairdryers plugged in and sitting near a water source and cooking handles of pots on stove turned outward where children might run into them. Accordion type child-proof gates were also mentioned as potential sources of risk as were trampolines and spring horses. Portable fans and poisonous plants were also mentioned.

Children napping upstairs and/or behind closed doors was also noted as a risk factor that the minimum standards might address specifically. It was noted that animals, particularly dogs, that were larger than the children in care could accidentally or purposely knock these children over and cause injury.

Specific concerns about infant safety were raised including specifying the appropriate spacing between railings in cribs, the practice of propping a baby's bottle unattended, the length of time spent in high chairs, and allowing infants to sleep in beds with no siding to prevent falling. The hazard of children sleeping on waterbeds with cats was also mentioned.

Finally, the issue of defining children in care with respect to other children in the neighborhood was raised. The RFH is often chosen as a child care alternative because of its home-like environment, including its place in the neighborhood. When children in care play with friends or the caregiver's own children have their friends over to the house it is sometimes confusing who to count as "in care."

E. SUMMARY

The data presented here provide a broad perspective from which to evaluate the minimum standards for RFHs. The data indicate that both caregivers and monitors appear to find the minimum standards an effective tool from which to base their professional behavior. Caregivers find the standards comprehensive, necessary, and clear and understandable. Results from the monitors' ratings of each standard indicate that the standards do vary in specificity but that this does not prevent the caregiver from complying with them. Three percent of caregivers cited unidentified areas of risk; most of these caregivers cited not monitoring as a risk. Monitors identified specific risks observed in their visits to RFHs, most of which were unique. With the exception of the call for more frequent and/or required monitoring visits and the need to deal with other businesses at the facility, no one item in the monitoring responses received more than 5 endorsements. In fact, the overwhelming majority of items were cited just once. It is important to examine this list to determine whether any conditions require immediate regulatory attention and this list will provide useful information when the minimum standards are next comprehensively reviewed. But our data indicate that the 1990 RFH minimum standards are, indeed, comprehensive in scope.

VI. THE MONITORING PROCESS

A. ATTEMPTED VISITS

A total of 5,280 RFHs (35% of the population of RFHs) were contacted in order to do a minimum standards evaluation for 2,813 facilities. Approximately one unsuccessful attempt was made for every completed RFH standard by standard evaluation.

The disposition of attempted visits to RFHs are as follows:

Disposition	Percent
Danger to Monitor	0.1%
Not enough time	0.4%
Refusal	0.4%
Complaint pending	0.5%
Moved	2.5%
No children in care	7.8%
Status change	8.9%
Other	9.1%
No answer	16.4%
Total non-complete	46.0%
Total complete	54.0%

B. TELEPHONE SCREENING

The pilot test provided a higher estimate of non-completions than we actually obtained apparently due to the fact that the pilot was conducted during the summer when many parents secure alternative means of care such as camps, etc. Nevertheless, a great deal of travel and per diem money could be spent traveling to RFHs which were not operating. In anticipation of the cost associated with non-completed visits, a telephone screening was instituted by TDHS. Prior to attempting a visit someone from TDHS would make an operating call, calling the provider and asking for an update on her address and status for our files.

Data on operating calls show that most were made during the months that the sample list was distributed to the monitors. The following two months of each quarterly cycle had much less call activity, presumably operating calls to replace RFHs on the sample list that were found non-operating by the monitor on-site (e.g., no children in care at the time of the visit). The average time between the operating call and the actual monitoring visit was 17 days.

There was some concern that the operating call would alert the provider that a visit was about to occur. Our data indicate, however, that the phone screening did not unduly influence the results of this study and, further, was a significant cost saving procedure.

If the phone call was perceived as an indication of an imminent monitoring visit, it would seem likely that the provider would come into compliance. The overall noncompliance rate, however, indicated that only 5% of the RFHs were in complete compliance. If not in complete compliance, it could be argued that the caregiver would at least comply with those standards which provided specific information about how to comply and/or seemed most important (e.g., the fire extinguisher). Recall that the noncompliance data show that the specificity of the standard was unrelated to noncompliance. Moreover, the standards with frequent noncompliance appear to be ones which would seem important to comply with if a monitoring visit was expected. If the operating call did have an impact on caregiver compliance behavior, it was minimal and isolated.

The cost savings of this procedure is calculated by determining how many of the non-completed group were determined by phone and how many were determined by a site visit. Fifty one percent of the non-completed group were determined by phone, 49% by a visit to the home. The reasons given for each case are listed below.

Reason	Determined by Phone	Determined by Visit
No answer	35%	43%
No children	18%	19%
Status change	19%	13%
Other	24%	13%
Moved	3%	8%
Refusal	--	2%
Time	--	2%
Complaint pending	1%	--
Percent of non-completed visits	51%	49%

The number of nonoperating homes established by phone was 1132. This number multiplied by the average travel cost ($19.63), as computed below, yields a savings of $22,221.16. The actual saved cost would be somewhat higher when the paid time commuting to and from the RFH is included. Further, the inability to complete as many monitoring visits due to this wasted time would increase this cost higher still. The operating call procedure appears to be effective and efficient.

C. RFHs VISITED

The number of visits per month is shown in the graph below. Pilot visits conducted in July and August are not included. The average number of visits per month is 265.

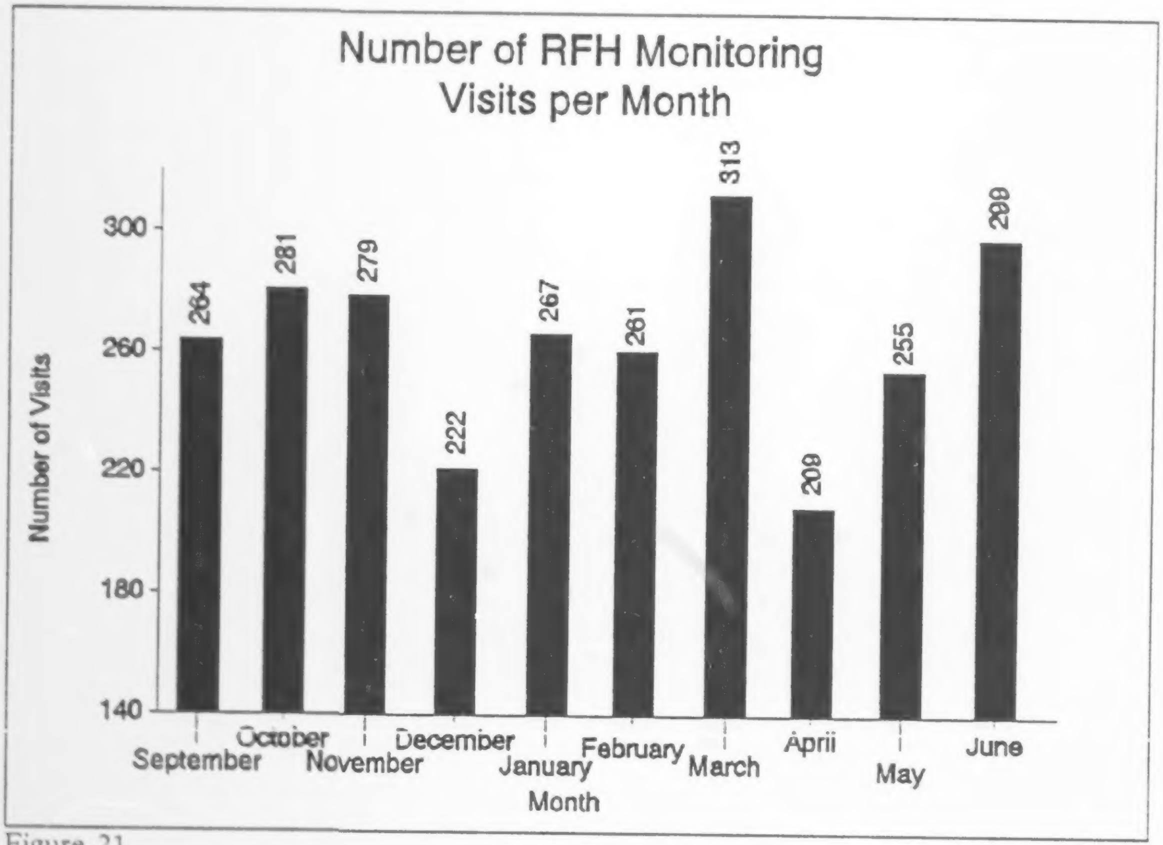


Figure 21

D. TIME IN RFH

The average time spent in the RFH was 107 minutes. The average time in the RFH was computed for each month to determine if a decrease in time occurred as monitors became more familiar with the required forms and routine of the visit. No consistent pattern emerged from month to month.

While in the home, monitors engaged in three primary tasks--observing the RFH for compliance, providing consultation to the caregiver, and completing the paperwork. The average percentage of time spent in each task was computed: 44% of the time was spent observing compliance, 26% consulting, and 30% doing paperwork. These percentages approximate actual minutes given that the average time in the RFH was 107 minutes.

E. PREDICTING TIME IN THE RFH

Analyses were run to determine what aspects of the RFH, the caregiver, or the visit influence the time actually spent in the RFH. Two key aspects of the RFH were the number of noncompliances and the number of children present during the visit, both expected to increase the amount of time. The caregiver's education, training, and professional activities were predicted to have a negative relation with time--caregivers with more education, etc., would likely know what to expect and how to respond to the monitor thereby decreasing the time of the monitoring visit. The caregiver's level of cooperation during the visit was also expected to have a negative relationship with time--the more cooperative, the less time. Similarly, the more the caregiver seemed to understand the standards, had a professional bearing, and was a better recordkeeper, as rated by the monitor after the visit, the less time it was expected to take. Finally, the location of the RFH--urban, suburban, or rural--was examined.

Correlations between these variables and the amount of time spent in the RFH were small, ranging from +.08 to -.07. The significant ($p<.05$) correlations are shown in the table below.

Predictor	Time
Negative	
Professional bearing	-.07
Recordkeeping ability	-.03
Understanding of standards	-.03
Positive	
Total noncompliances	.08
Number of preschool age children	.05
Number of children	.04

Caregivers rated high in professional bearing (-.07), recordkeeping ability (-.03), and understanding the standards (-.03) are each associated with less time in the RFH. Caregivers with relatively more noncompliances (.08), preschool age children (.05), and total children (.04) are each associated with more time in the RFH.

If variables expected to influence the amount of time in the RFH do not, the question is raised what variables do influence the amount of time. Anecdotal evidence provide several possibilities. First, many caregivers are eager to spend time talking with monitors about their work. Many caregivers appeared to enjoy describing their work in some detail to the monitors. Second, the personal setting of the RFH provides an environment in which it is easy for the caregiver to open up about personal issues that may impact her work. The monitor then has to take time to handle the extremely delicate task of acknowledging the provider's issue and refocusing the discussion back to the inspection visit.

The monitor also has pressures on time. Of course, any number of personal reasons may influence the amount of time the monitor stays in the RFH. Professionally, the style of caseload management may also have an effect. For example, a trip to the rural communities is planned to maximize the number of RFHs visited with the most efficient travel route. Making visits to the planned number of RFHs may require some juggling of time, as each RFH presents its own unique circumstances.

Finally, the interaction between the caregiver and the monitor is likely to influence the amount of time. There are some providers that a monitor feels connected with, perhaps can learn from, and so the visit will take more time. Sometimes the provider and monitor are eager to finish the visit as quickly as possible. The overwhelmingly positive response to the monitors suggest that they handled any negative interpersonal circumstances with the caregiver with tact and diplomacy. This may include making the visit as brief as possible.

F. RECORDING OF MONITORING VISITS

After the visit, monitors were responsible for entering information about the visit on the Licensing computer system (ACCLAIM) and for forwarding the evaluations and questionnaires to state office for analysis. The ACCLAIM computer entry was made an average of 4 days after the evaluation date. The required paperwork was received in state office an average of 10 days after the monitoring visit. These averages include weekend days.

G. CAREGIVER REACTIONS

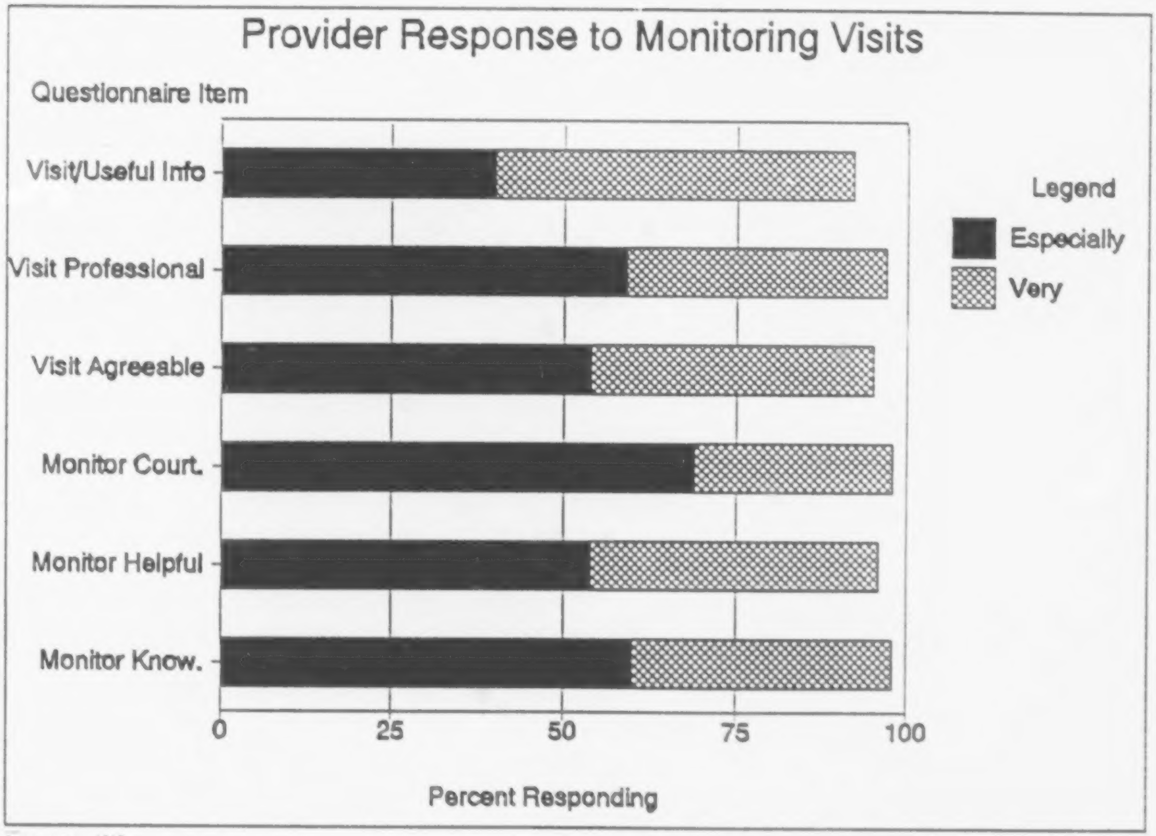


Figure 22

The caregivers' anonymous questionnaire allowed for a different perspective of the monitoring visits. Both the monitor and the visit were rated on several dimensions. The chart shows the frequency of response for the two most favorable responses for the items concerning the monitors and the visit in the questionnaire. The response was overwhelmingly positive.

Of the 47% responding with the questionnaire, 25% wrote additional comments on the sheet. By far the most frequent comment concerned the high degree of professionalism and courteousness of the monitor (46% of all comments) with 15% of these specifically stating that they had anticipated the visit with fear but had been put at ease by the monitor and very satisfied with the visit. Only one caregiver questionnaire had a negative comment about a monitor.

Support for monitoring visits was evident in 18% of the comments although 10% of these encouraged announced visits. Compare this with 6% of comments in disagreement with the visits.

Finally, comments about the standards were split about equally. Fourteen percent supported the standards and/or urged stronger standards, 14% disagreed with one or more of the standards.

H. RECOMMENDED IMPROVEMENTS TO THE MONITORING SYSTEM

The questionnaire that monitors completed after the visit had an item for writing in suggestions for improving the monitoring system. Suggestions were given on six percent of these forms. The most frequent was the suggestion to require annual inspections (75%) followed by shorter or less confusing forms (10%).

Other suggestions were given in other formats. Monitors sometimes sent letters or forms they had developed in which were then copied and sent to all the monitors. For example, a form letter designed to follow up those RFHs on the sample list that could not be contacted by phone and/or visit was developed to help keep our list of active RFHs current.

Monitors also shared information directly with each other. For example, locating rural RFHs was often difficult and the idea was given to get directions while doing the screening calls if it appeared that the RFH would be hard to find.

Finally, several monitors made suggestions for cosmetically improving the standard by standard evaluation checklist which were subsequently incorporated in revised versions of the form.

I. COSTS

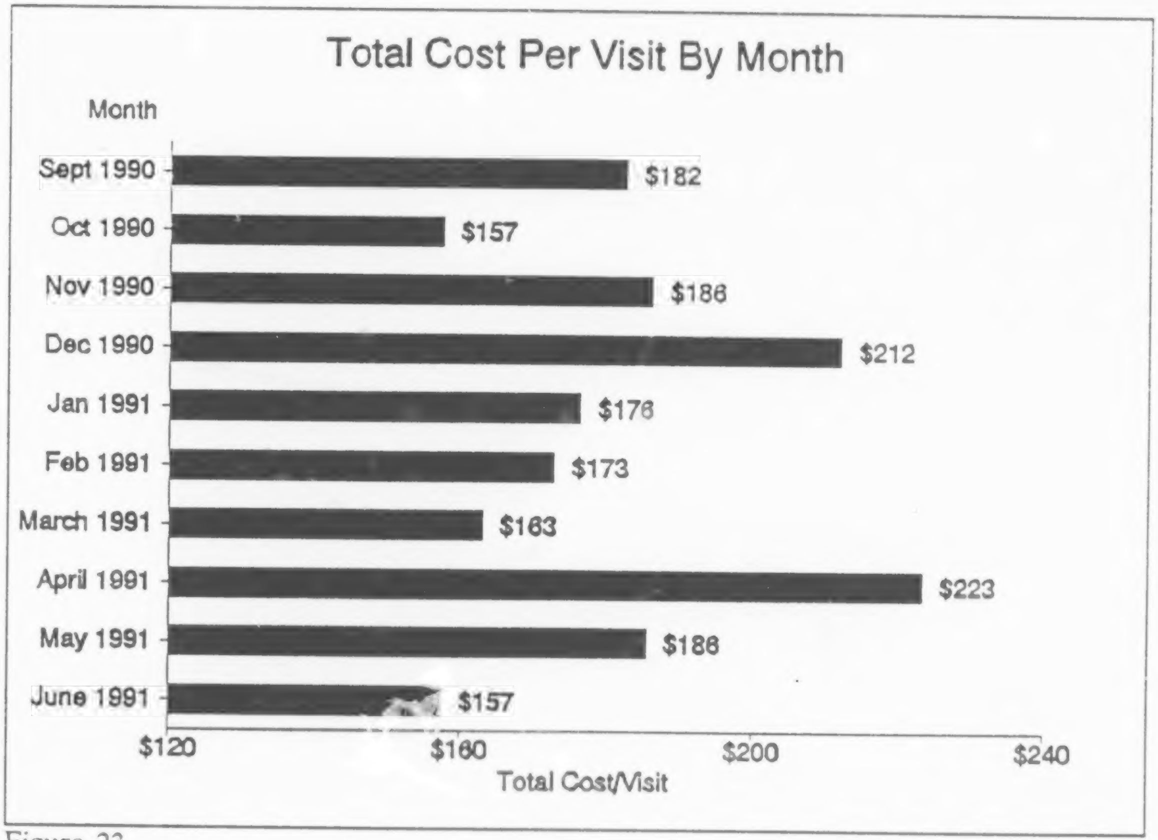


Figure 23

1. Total cost per visit

The total expenditures for the project over the year, $541,883.00 was divided by the total number of visits, 3065, to arrive at an average cost per monitoring visit, $176.80. The cost per month is shown in the chart above. To show the variance in this cost across the state and year, the cost for a monitoring visit per month for each regional area is also shown.

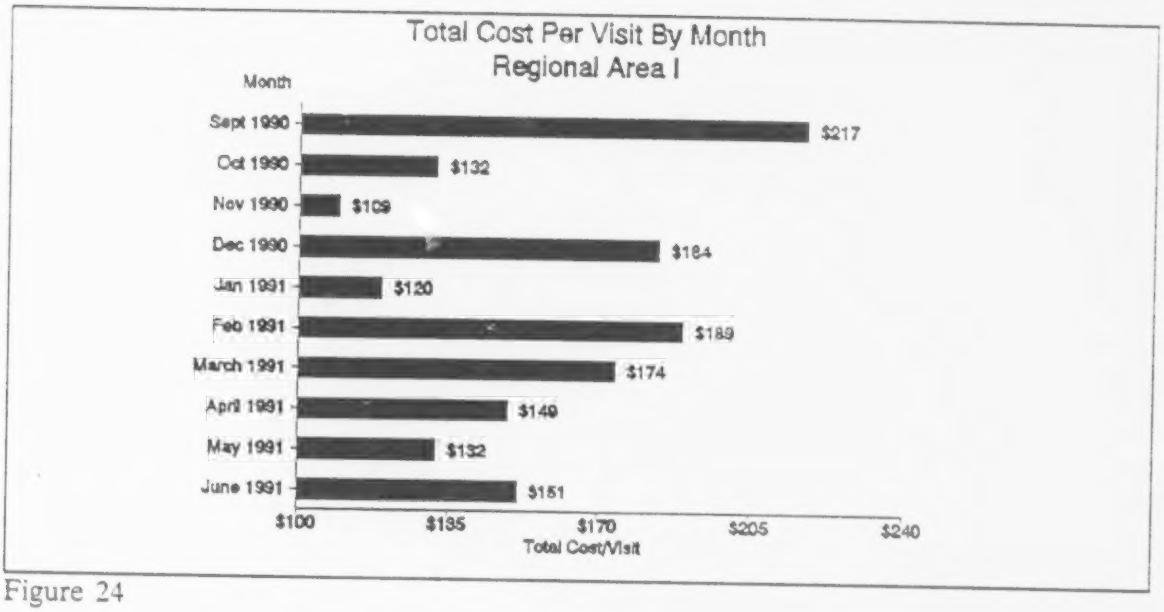


Figure 24

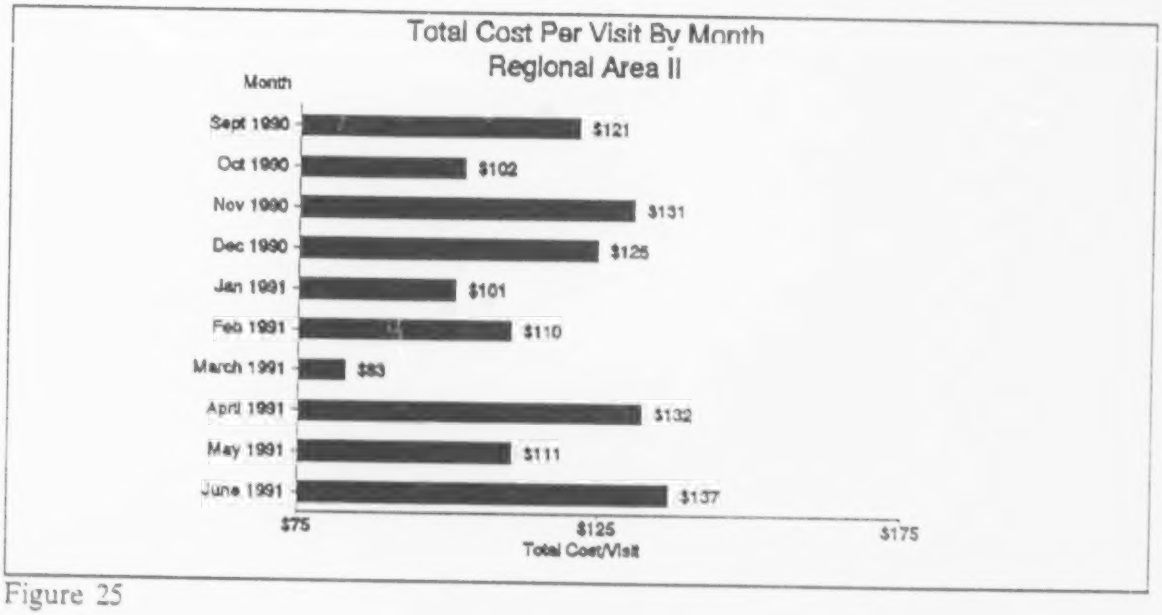


Figure 25

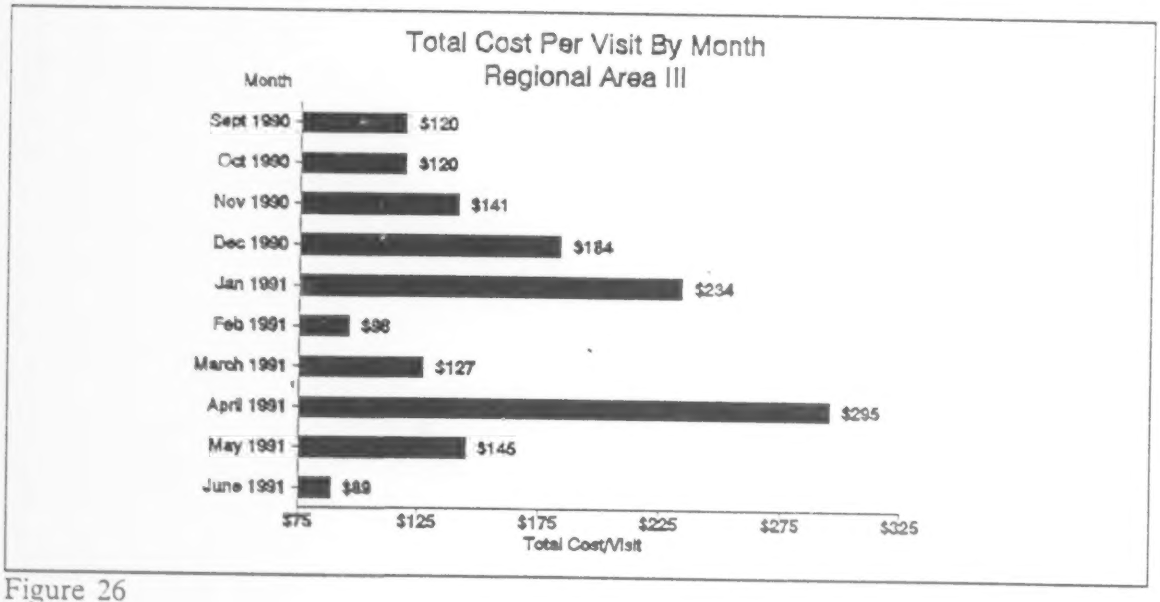


Figure 26

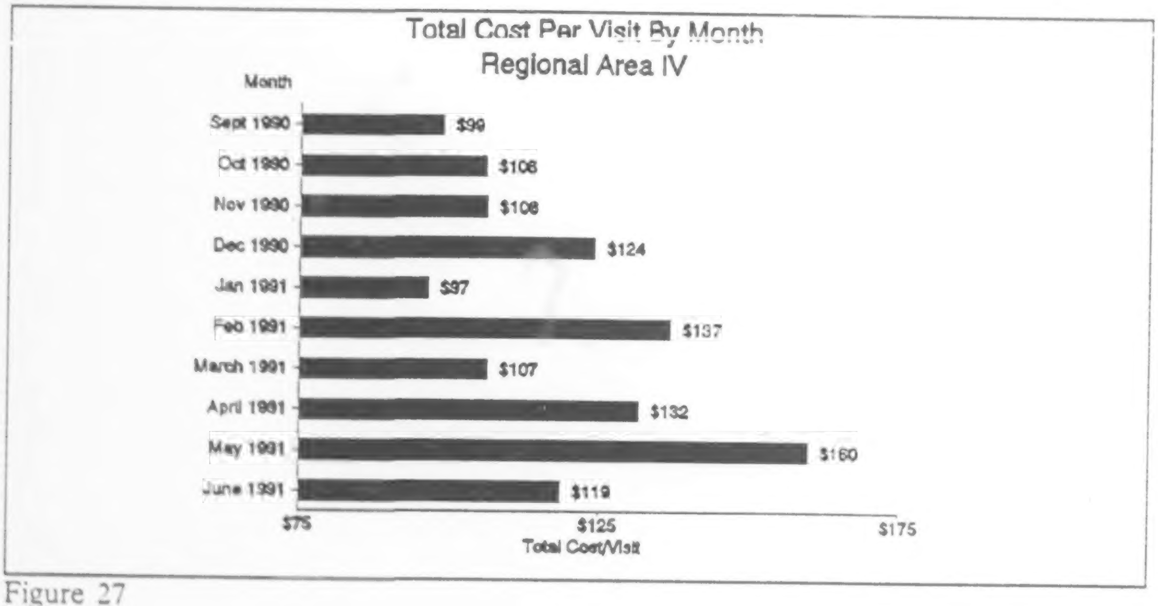


Figure 27

2. **Travel cost per visit**

The cost of travel was divided by the number of monitoring visits for an average travel cost per RFH of $19.63. No definable pattern emerged when travel cost per visit was examined by month. Again, the variance of the travel cost is shown in the graphs showing the travel cost per month for each regional area.

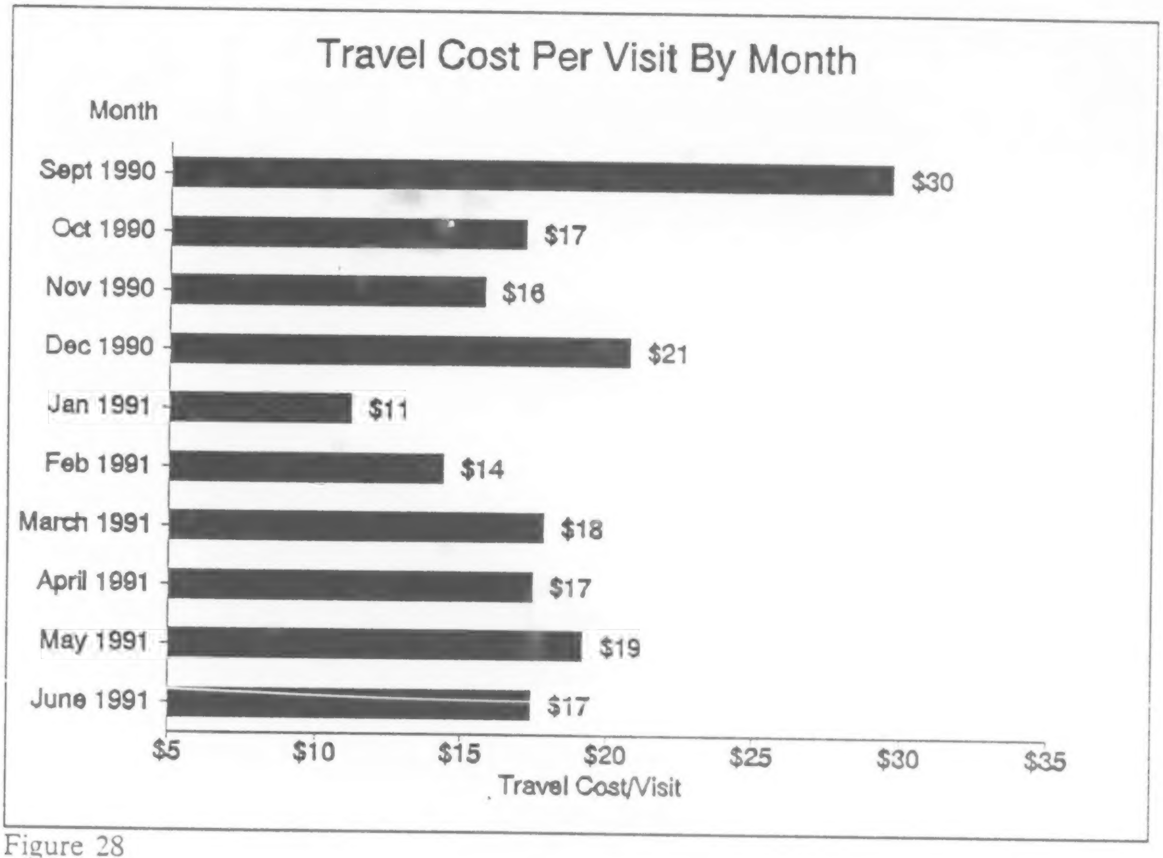


Figure 28

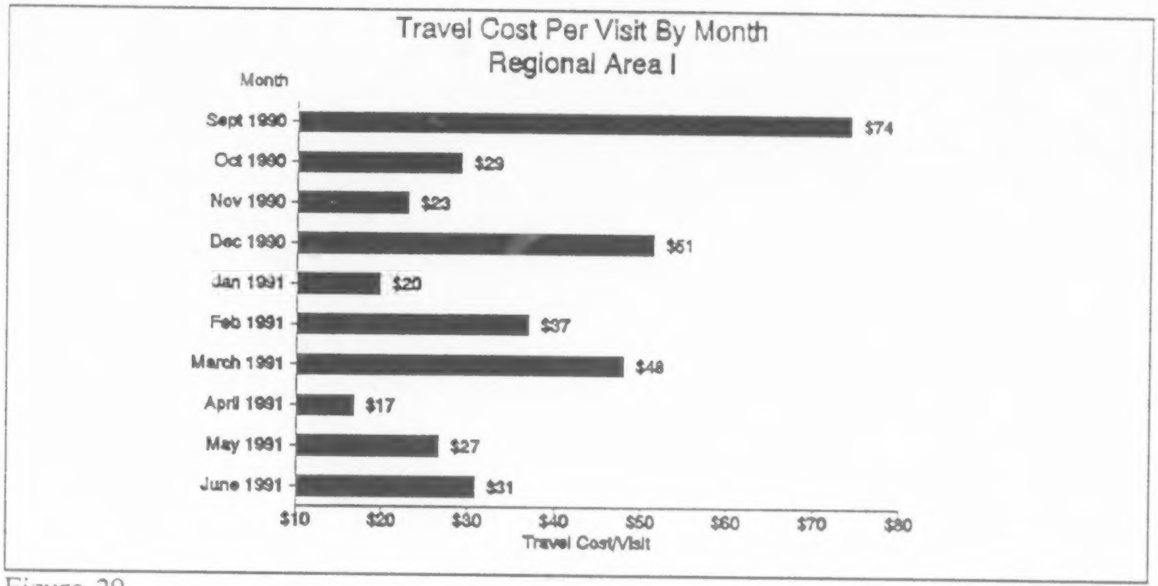


Figure 29

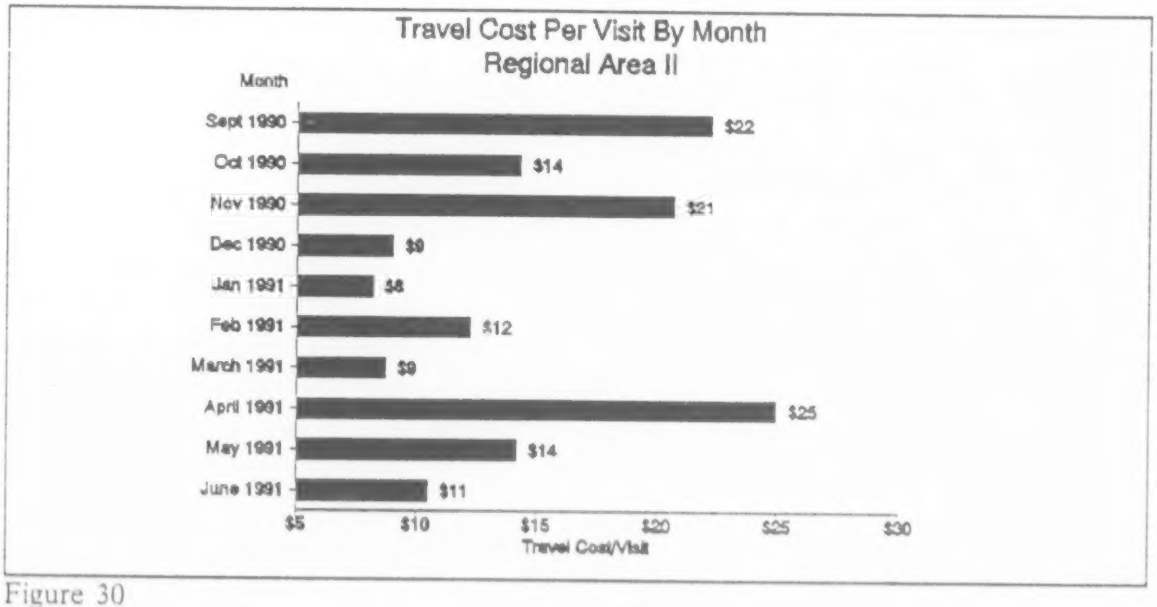


Figure 30

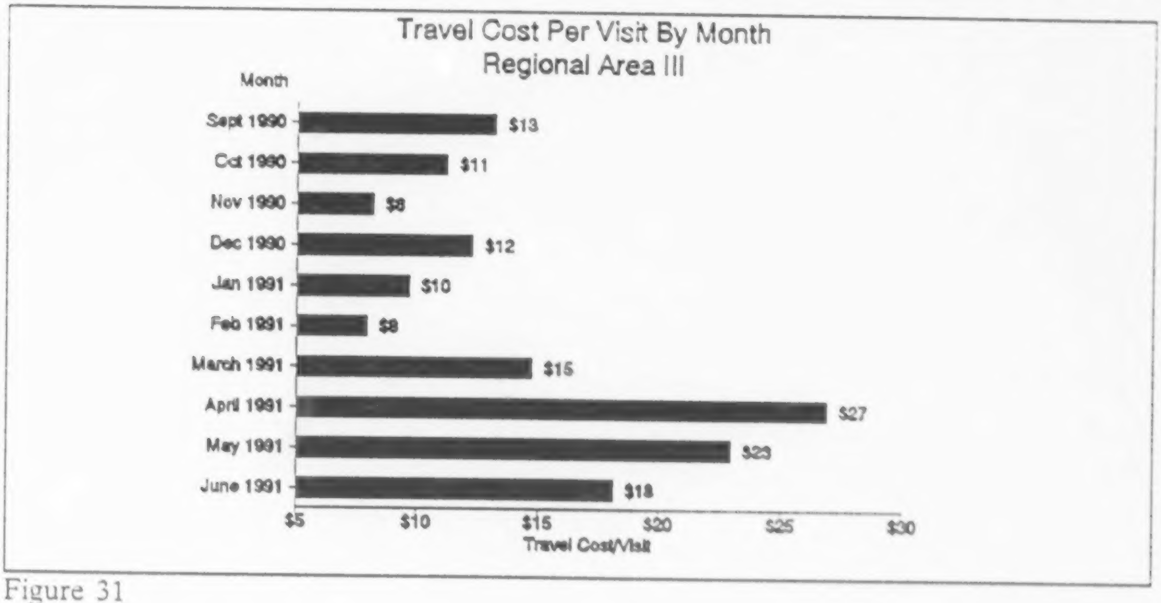


Figure 31

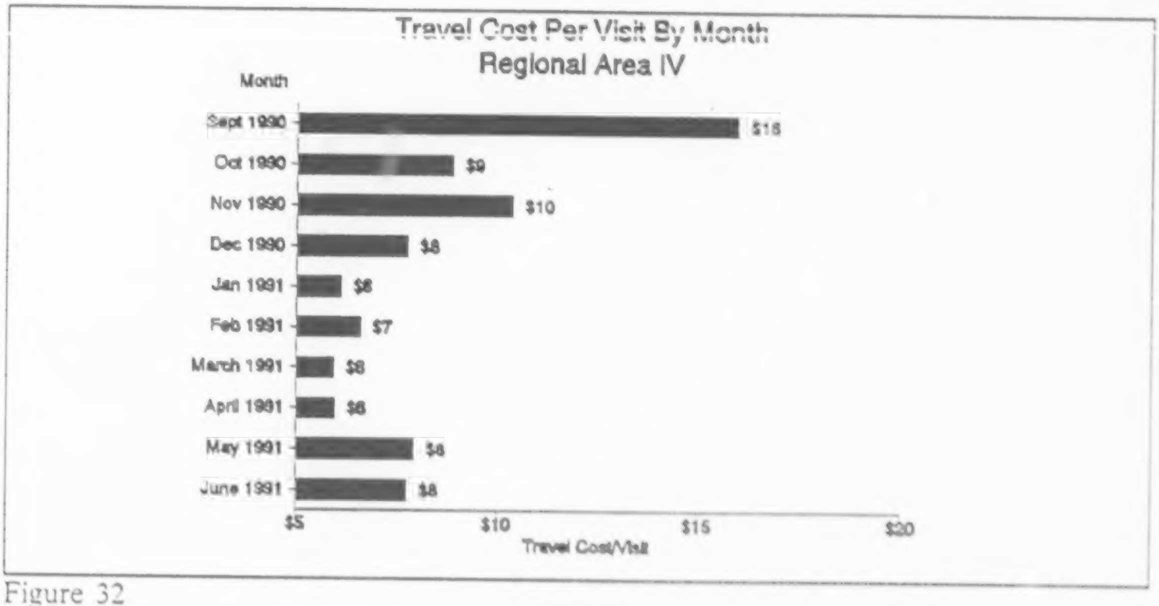


Figure 32

3. Budget summary

The following table shows a budget summary comparing projected and actual costs of the project. Actual costs were $1,969 over projected costs.

Budget Summary

	Projected	Actual
Salaries	$438,024	$367,430
Fringe benefits	118,963	100,025
Overhead	--- ---	14,265
Travel	35,000	60,163
Contracts	102,627	154,700
TOTAL	**$694,614**	**$696,583**

Projected funds include $631,464 federal monies and $63,150 (10% of the grant allocation) in state monies.

Fringe is calculated as 15% of salary plus $2,662.93 per position.

VII. PUBLIC INFORMATION CAMPAIGN

A. IDENTIFYING APPROPRIATE INFORMATION

The primary goal of the public information campaign is to inform parents about the regulation of family day homes, specifically that registration of family day homes differs from the licensing of day care facilities and that parents must take a more active role in monitoring the family day homes in which their children are enrolled. In addition to factual information about their role and TDHS's role in regulating RFH, the public information campaign was designed to teach parents what they can do to encourage caregivers to exceed the minimum standards and provide the highest quality care for their children.

Our first objective was to identify the appropriate theme around which to build this campaign. This type of campaign carries its message to more than the primary population of interest and, thus, serves to inform other populations as well. To focus the information in this campaign to the right audiences was also a major objective.

A 20-member panel of caregivers, regulators, parents, and child-care advocates assembled to generate ideas for the campaign in September 1990 and again in November 1991. Facilitated by an in-house marketing specialist, the panel first identified the potential audiences for the campaign and developed the appropriate messages for each. In addition, methods for disseminating the messages to each audience were identified. Subcommittees reviewed and refined the messages appropriate to each target audience and how that message should be relayed in the interim and, in the second meeting, refined the results of their work in discussion with the rest of the group.

B. THE MEDIA CAMPAIGN

The direction and campaign themes that emerged from this marketing analysis performed by the panel provided the basis for purchasing marketing services from NCNB Texas, a banking institution known for its support of children's issues. NCNB Texas was responsible for the creative development of two full, state-wide advertising campaigns/themes, including TV, radio, newspaper, billboards, posters, and brochures.

Based on the input from the marketing analysis performed by TDHS and a careful review of all materials TDHS was currently using to inform the population about child care, NCNB Texas developed two campaigns to be implemented consecutively. The first theme, "In the dark," was designed to motivate parents to take an active role in selecting and monitoring day care for their children. It is to run from November 1991 through April 1992. The second theme, "Put yourself in your kid's shoes," was designed to motivate parents to be more concerned about the quality of the day care they receive. It is scheduled to run from May 1992 through October 1992. Six major markets are targeted for this campaign: Dallas-Fort Worth, Houston, San Antonio, Austin, Lubbock, and El Paso.

Three brochures were also developed for distribution to the public. One brochure provides guidelines for parents in choosing child care, including a description of the difference between licensed day care centers and registered family homes. A second brochure informs parents about what things to look for in choosing licensed day care for their children. A third brochure focuses on things to consider when choosing registered family homes. These brochures were also translated into Spanish.

A breakdown of specific tasks performed by NCNB Texas and their costs follows:

Task	Cost
--Creation and design of campaign	0
--Full color photos to be used on outdoor, posters and ads	4,000
--Full color photos on covers for three brochures	3,000
--Brochures (finished/bound) 90,000 English 15,000 Spanish Extra covers (flat/untrimmed) 60,000 English 10,000 Spanish	90,000
--50,000 full color posters	13,000
--300 outdoor posters	20,000
--Two 10 second TV spots	20,000
--Radio spots (60 seconds) English and Spanish versions	4,000
--Newspaper (6 months)	0
--Translation services	700
--Placements services	0
TOTAL	$154,700

Note that the creative development of these campaigns was provided free by NCNB Texas at an estimated savings of $450,000. In addition, NCNB Texas will help place the television and newspaper spots as advantageously as possible.

TDHS has an in-house public information office with a representative in each of the 12 regions across the state. These twelve public information officers are also assisting the Licensing Department in getting air time for the radio and television spots, as well as stories in the local newspapers.

C. THE 1-800 CHILD CARE HOTLINE

Motivating parents to give more consideration to their choice of child care was the primary theme of this campaign. In all the media spots, parents are provided a 1-800 number to get more information. This automated hotline number is maintained at the state office of TDHS and is monitored 24 hours a day. Callers are instructed through a series of messages tailored to their anticipated child care needs. Messages can be obtained in either English or Spanish.

Once a caller's needs are identified, the number of the local TDHS office which is capable of meeting those needs is given. Callers who have unanticipated needs or unique questions about child care talk to a trained operator who directs their calls to state office staff or others as necessary.

A lot of phone calls are expected to be generated by our public information campaign. At this time the marketing campaign is just beginning and relatively few phone calls have been received. The demand for information will determine whether this hotline needs to be expanded.

D. OTHER BENEFITS

Our marketing analysis identified secondary targets of our public information campaign with specific ways of delivering this information. The results of this analysis have been used as a guide by TDHS in addressing these various audiences, both in formal and in informal settings. Brochures on choosing child care have been sent to health care professionals who work with parents and children, as well as educators, PTAs and clergy. The campaign itself has served to raise the interest of child care providers, child advocacy groups, and the legislature.

The impact this public information campaign will have in Texas is indeterminate at this point. We anticipate the campaign to be successful and play a vital role in the regulatory program for registered family homes in Texas.

VIII. SUMMARY AND RECOMMENDATIONS

Project CHERISH had five major objectives concerning the regulation of family day homes:

1. Collect data about the RFH facility, children and caregiver.
2. Obtain information about compliance with the minimum standards.
3. Evaluate the minimum standards.
4. Evaluate the monitoring plan.
5. Implement a state-wide public information campaign to increase parents' motivation to monitor their child care.

A 20% random sample of RFHs across the state, stratified by 12 administrative regions, was used to ensure that the data would be representative of all RFHs in Texas. In this summary the major findings with respect to each of these objectives are briefly described and the implications are discussed.

A. THE RFH FACILITY, CHILDREN, AND CAREGIVER

1. The facility

The most uniform thing about RFHs is that almost all of them (92%) are in single family homes. If we assume that most parents with young children also live in single family homes, this observation may not be surprising. This finding is also consistent with information in the U.S. Department of Education 1990 day care study prepared by Mathematic Policy Research, Inc., "Profile of Child Care Settings: Early Education & Care in 1990" which found that only 5% of family day care providers operate in apartments or condos, presumably because of zoning laws, homeowner association rules and, in some cases, space requirements.

On the other hand, this may reflect that individuals operating family day homes in apartments or multi-family units are less likely to register their facilities. If the objective is to track down unregulated family day homes, it may be best to look where family day homes are currently underrepresented under the regulatory net: apartments, duplexes, and other multi-unit facilities.

Only about 1 in 5 RFHs have water located at the facility. There is a surprising lack of wading pools, especially given the hot Texas summers--only about 1 in 8 RFHs have them.

The minimum standards on wading pools are likely to contribute heavily to their non-use. The standards specify that if the youngest child in the group is under 24 months and there is only one adult, only one child can use the wading pool. Typically, only one caregiver is present in the RFH and the number of children in care usually exceed the minimum number of four which mandate registration (the average is 5). Further 63% of RFHs have an infant present. This adds up to not using a wading pool. To avoid the danger of overheating from playing outdoors in the summer or keeping children indoors during the heat of summer, caregivers might benefit from training in safe water play outdoors for children.

A facility may have a pool or piece of play equipment, but if the caregiver states that it is not used by children in care, it is not evaluated for compliance. The difference between the number of these items present and whether or not they were evaluated is very large and, thus, noteworthy. The difference for the major items examined in this study are presented below.

The wading pool is an anomaly that seems to reflect the practice of evaluating the standard on the basis of discussion with the caregiver and marking present only when the wading pool has been seen. Otherwise, from 30 to 42% of these items were *present but not evaluated* for compliance. Given the likelihood that children in care may gain access to pools and playground equipment even if not allowed, the practice of evaluating only those items that the caregiver says she uses should be reevaluated. If pools or play equipment are not used, physical safeguards should be required to ensure their inaccessibility to children who may gain access while the caregiver is attending to something else.

Item	Number Present	Number Evaluated	Percent Evaluated	Number not Evaluated
Water				
Swimming pool	164	95	58%	69
Wading pool	320	476	--	(156)
Play Equipment				
Swing	1812	1263	70%	549
Climbing structure	1663	992	60%	671
Slide	1758	1162	66%	596

Safety and training about play equipment and animals seems essential since more than half of RFHs have them. Although virtually all facilities meet the minimum structural guidelines, about 1 in 5 RFHs do not have a smoke detector, a number which is likely to be reduced through orientations to new providers.

2. The children in care

The data show that RFHs in Texas have an estimated 68,640 children in care, approximately 76% of the capacity for the number of family homes registered. This is consistent with the Department of Education's child care study which found that 82% of spaces in family day care were filled at the start of 1992.

Although infants are present in 63% of the RFHs, infants make up only an estimated 23% of the total population of children in RFH care with preschool age (59%) and school age (18%) making up the rest. A common assumption is that parents place infants in day home settings rather than day care centers. The home-like environment of family day home care is similar to the child's own home, thereby easing the separation process between parent and child. Does the observed percentage of infants in RFHs reflect this assumption?

The percentage of school age children is largely a function of when the visit was made. Because school age children are in school much of the day from mid-August through May visits made during the day would have no school age children present in the RFH. Excluding school age children thus provides estimates which more realistically parallel the relative percentages for the infant and preschool age groups in society.

Revising the figures to omit school age children provides population estimates of 28% and 72%, for infants and preschool age children in RFH care in Texas, respectively. Since the infant period covers about 2 years and the preschool age period includes about 3 years, it would be expected that infants would make about 40% of the population (2 years out of the 5 years covered by both age groups) and preschool age children would make up about 60% of the population. There may be a slight tendency **not** to use RFHs for infant care. The tendency to keep newborns at home for a time, and the limits on the number of infants specified in the minimum standards, however, make the observed 28%/72% split appear reasonable.

3. The caregiver

One in ten caregivers is 61 years or older. The physical capabilities of the caregiver were in some cases a cause of concern either because of old age or some physical condition. For example, one provider claimed to be unable to take CPR classes, being too weak to provide the breath necessary for mouth-to-mouth resuscitation. Another was too obese to perform the physical maneuvers required for CPR. In general, however, caregivers are younger and more educated than those in the 1977 RFH study done by TDHS.

Professional networking, minimum standards training, and having a high school diploma are all associated with more training hours both in the past two years and since February, 1990. Especially striking is the difference between child care association members and nonmembers. The emphasis on training in both local and statewide associations is acknowledged and encouraged.

The variations in age, education, and experience of caregivers suggest that provider training will require targeting specific sectors of this population, not necessarily for the content of the training, but for the manner in which the training is delivered. Elementary level training to highly skilled and motivated caregivers could have a demoralizing impact. Conversely, higher level training delivered to inexperienced caregivers could also convince providers that training is a useless exercise. Different content may also be necessary for different providers as they differ in age, experience, and training.

Training needs are identified both by what training has been taken and what training caregivers desire to have. The two major areas of training requested by caregivers--business management and age and developmentally appropriate activities--are also among the least represented of all training areas in training received.

Food program sponsors provide a great deal of training to RFH providers. Because they have the systems in place to provide training, they are identified as a potential source for material to develop training systems. Further, although their primary training is likely to be nutrition related, they may be willing to provide training in other areas.

B. COMPLIANCE WITH MINIMUM STANDARDS

1. Rates of noncompliance

Providers are complying with the minimum standards, with RFHs averaging only 7 (of 113 possible) noncompliances, a rate of 6%! On the other hand, 95% of RFHs had at least one noncompliance cited and 75% of RFHs had 4 or more noncompliances.

The pattern of noncompliance is clear and definable. Five standards have noncompliance rates greater than 50% while 80 standards had noncompliance rates of less than 10%. In fact, those five standards account for 35% of all noncompliances observed. Twelve standards have noncompliance rates greater than 25% (including those with over 50% noncompliance), accounting for 63% of the observed noncompliances. Twenty-one standards with noncompliance rates of 15% or higher are identified and together account for 77% of all noncompliances.

Identifying standards with high noncompliance is useful for developing and refining the RFH orientation and training of providers. That so few standards account for such a large portion of the noncompliances found suggests that the overall level of noncompliance could be dramatically reduced if an intensive monitoring program were instituted in which every RFH was inspected on only those 21 standards. A partial monitoring visit focusing on these 21 standards would take less time and more RFHs could be inspected in a shorter period of time. This approach would be temporary, until every operating RFH in the state is visited, to ensure a quick and dramatic lowering of the average noncompliance rate. Once completed, a long term comprehensive monitoring plan which includes a preregistration visit and a random sample would be instituted. The long term permanent plan is described in a following section.

2. Patterns of noncompliance

The 1978 RFH study allows a historical look at noncompliance rates for three specific standards which both the old and new standards had in common. As seen in the table below, there is substantial increase in the noncompliance rates for each standard.

STANDARD	1978	1991	DIFFERENCE
Immunization records	45%	58%	+13%
Family TB tests	39%	56%	+17%
Emergency medical care forms	32%	43%	+11%

3. Increasing compliance

The underlying assumption in the minimum standards that increasing caregiver competency increases compliance appears justified. Significantly less noncompliance is found for high school graduates, those with more training, those belonging to child care organizations, and those attending minimum standards training than their respective counterparts. Further analysis revealed that the combination of the required training and a high school diploma or GED is associated with an even lower level of noncompliance. Finally, participation in professional activities, in addition to the competencies required by the standards, is associated with lower levels of noncompliance than the competencies alone. Encouraging participation in professional activities, particularly the child care associations is likely to lower noncompliance rates significantly.

4. Predicting RFHs with high noncompliance

Analyses of the noncompliance rates in different RFH environments show significantly more noncompliance in some areas compared to others. RFHs in multifamily units (not apartments), bordering heavy use streets, and in poorly kept or high safety risk neighborhoods are identified as having less compliance. Should a need arise to prioritize RFH monitoring visits, these predictors provide objective indicators that may assist in establishing priorities.

5. Problems in complying

About 1 in 3 caregivers cites a problem in meeting the standards. Of those providers who do, lack of understanding is the most pervasive difficulty. One example of this is the provider who does not understand the benefits of having her own phone number posted near the phone. Monitors report a frequent consultation is explaining that the phone number may be useful in emergencies when someone unfamiliar with the number is called upon to report an emergency.

A method for increasing understanding is to provide a rationale for each standard in the published minimum standards. This is the format soon to be recommended by the U.S. Department of Health and Human Services who are, in association with the American Public Health Association and the American Academy of Pediatrics, proposing a national set of standards guidelines for out-of-home day care. The rationale should also include an example or two of how compliance with the standard has been met.

In addition, this lack of understanding should subside as caregivers receive more of the required training. The most frequently cited problem, however, is finding time to attend training. Innovative strategies are necessary to deliver training to providers who work a full week, at least. They must either hire, or otherwise obtain the services of, a qualified substitute or attend training in their off hours. Self study courses, videotapes, and other methods for providing the caregiver flexibility in scheduling training are essential.

The other major problem is cost both for training and for obtaining or maintaining materials necessary for fire prevention, safety, and activities. Still, 93% of the caregiver survey respondents say that the costs to comply are at least moderately reasonable. Disagreement with the philosophy, or underlying rationale, of the standards is cited primarily with respect to no smoking in the RFH and with limits on discipline. Providing training on alternatives to discipline and techniques for creating a smoke-free environment may help alleviate the extent of disagreement.

When compliance is especially problematic for the caregiver on a particular standard she may request a waiver/variance to get more time or use an alternative means for complying with the standard. An increase in the number of waivers requested is one index of caregivers wanting to comply but finding difficulty in so doing. The average monthly waiver/variance request rate for the past five fiscal years are 7.5, 3.9, 1.3, 9.4, and 29.8, this last figure for fiscal year 91 which ended August, 1991 and roughly coincides with the dates of Project CHERISH.

C. THE MINIMUM STANDARDS

Analyses of the minimum standards converge to indicate that the standards are useful, comprehensive, and perceived positively. Although the specific standards vary in their specificity of what constitutes noncompliance, this lack of specificity is not related to noncompliance--in general, providers interpret the standards in the manner that they were intended. On the other hand, identifying noncompliance in the monitoring visit is associated with being able to directly observe the noncompliance rather than inferring noncompliance from discussion with the caregiver. And, as expected, technical consultation is most frequently given when noncompliance is observed.

Caregivers overwhelmingly approve of the standards, agreeing that they promote the health and safety of children, cover critical areas of safety, are necessary, and are clear and understandable. This is a strong finding especially since most of these ratings were in an anonymous caregiver survey after the visit. This finding also reflects the professionalism of our monitors who helped caregivers understand the minimum standards and the regulatory process.

Monitors and caregivers both identified areas of risk that the minimum standards might address in the future. These lists should be examined for issues that require immediate action, if any, and then saved for use in the next review of the RFH minimum standards.

D. THE MONITORING PROCESS

The pilot testing provided practically all the information necessary to design specifics of this study including forms, processes, and procedures. Two major issues were identified, both related to the costs of travel. First, the sampling procedure needed to have the flexibility to replace RFHs found not to be operating with ones that were nearby. Second, a telephone screening procedure was adopted to identify RFHs that were not operating any longer before any trip would have to be made to the facility. Both procedures resulted in significant fiscal savings.

The average time in the RFH was about one and three-quarter hours and most of that time was spent by the monitor observing. There was no consistent pattern to either the time spent in the home or how that time was spent from monitor to monitor, from visit to visit. Several factors did have a minor but consistent impact on the time: More noncompliances, more children, a caregiver who had little understanding of the standards, and poor recordkeeping were found to have small but significant correlations with increasing time in the RFH. Anecdotal evidence suggests that the time spent in the RFH is in large part a function of the interpersonal relationship established between the monitor and the caregiver.

Our monitors had been trained to effectively balance the personal with the professional aspects of these home visits and the anonymous caregiver response to the visits suggest our monitors did a superb job. The caregiver was considered courteous, helpful and knowledgeable and the visits professional, useful, and agreeable by over 95% of caregivers completing the questionnaire. Monitors were also professional in carrying out their duties. The average time for completing all required paperwork was well within the allotted time frames prescribed at the beginning of the study.

E. THE PUBLIC INFORMATION CAMPAIGN

The public information campaign appears to have all the elements of success when it is fully implemented due in large part to our marketing specialist who supervised the process and to NCNB Texas who generously donated the creative talent. This ensured the campaign was professionally developed and ensures that it will be professionally implemented. The six major markets now have the materials to being the campaign.

A 1-800 hotline number is an integral part of this campaign and is expected to be used frequently by parents who desire information about day care.

F. THE EFFECTS OF MONITORING ON COMPLIANCE

The caregiver competency approach has been shown to significantly reduce noncompliance. On average, possession of a competency characteristic is associated with noncompliance rates that are about 30% less than that associated with nonpossession. Nevertheless, there is still noncompliance. Even those possessing caregiver competency characteristics still have from 5 to 7 noncompliances on average. Moreover, 19 of 20 RFHs will be in noncompliance with one or more of the minimum standards. Three of four RFHs have at least 4 noncompliances.

There is only one activity associated with complete compliance and because they have participated in that activity 20% of the RFHs in Texas have now demonstrated complete compliance with the minimum standards. That activity is the monitoring visit. The monitoring of RFHs thus alters the general level of noncompliance observed in this study in profound and beneficial ways. Before this study, 5% of the RFHs in Texas were in complete compliance. As a result of this project, at least 20% of the RFHs in Texas are in compliance.

Given the impact of the monitoring program on compliance rates it is well to consider various ways to implement such a program to ensure maximum coverage of the RFH population and ensure a valid picture of the state of RFHs in Texas. The monitoring plan thus far has relied on unannounced random sampling (with no RFH monitored more than once) to ensure that the information obtained from the visits would be representative of RFHs in Texas.

An alternative approach is to visit each RFH as part of the registration process to ensure that it is in full compliance with the minimum standards before a registration certificate is given. This method does not allow an accurate picture of operating RFHs in Texas but it does have several advantages. First, the RFH will be in full compliance **before** it is allowed to operate. Second, caregivers will have a complete understanding of the minimum standards and how they are applied, increasing the probability that they will stay in compliance. Third, the visit is expected and providers will be motivated to comply before the visit occurs, thereby decreasing the costs associated with follow up visits. Finally, an initial visit provides the opportunity for TDHS to influence the professional development of the provider. For example, TDHS could, as part of the visit, work with the provider to identify areas of strength and weakness and develop an appropriate, suggested training plan.

A **combination** of preregistration and random visits, however, would ensure maximum impact on decreasing noncompliance rates and would allow for continuous monitoring of compliance rates over time. What the appropriate combination should be is largely a function of resources. If all RFH applicants are visited, for example, there may be little resources left for a random visitation program for operating RFHs.

As noted above, a dramatic reduction in noncompliance rates would occur if a partial monitoring program of all operating RFHs on the most problematic 21 standards would be implemented. A systematic partial monitoring of all operating RFHs not yet monitored would quickly reduce the overall level of noncompliance. Once all RFHs have had either a full or partial monitoring visit, a permanent random sample approach could be implemented.

It is therefore recommended that all RFH applicants receive a full monitoring visit as part of the registration process and that a partial monitoring visit focusing on the 21 least complied with standards be done for every operating RFH as soon as possible. Once all RFHs have been monitored, a small random sample full monitoring program should be implemented along with the preregistration visit program.

APPENDICES

Appendix A	Minimum Standards for Registered Family Homes
Appendix B	Guidelines to Determine Appropriateness of Monitoring Visit
Appendix C	Instructions for Choosing Homes to Visit from the Sampling List
Appendix D	Research Instruments
Appendix E	Project Staff

APPENDIX A
MINIMUM STANDARDS FOR REGISTERED FAMILY HOMES

Registered Family Home Manual

July 1, 1990
Texas Department of Human Services

Texas
Department
of
Human Services

COMMISSIONER
Ron Lindsey

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March 9, 1990

Dear Caregiver:

The attached document is the revised ***Minimum Standards for Registered Family Homes***, which will be effective July 1, 1990. The Board of the Texas Department of Human Services approved these standards for adoption on January 18, 1990.

After considerable input from parents, the Ad Hoc Committee on Family Day Care, the State Advisory Committee on Child Care Facilities, other interested citizens, and you, the department developed proposed revisions to the existing standards. The proposed standards were published in the ***Texas Register*** and were sent to all registered caregivers for a 60-day public review and comment period. During August and September of 1989, the department held 18 statewide public hearings and received comments from over 1,500 people. The department, along with the Ad Hoc Committee and the Advisory Committee, evaluated the public comments keeping in mind the following considerations:

- The department recognizes the difference between center and home-based care. We do not routinely inspect registered family homes; therefore, the competency and training of the caregiver are vital to ensuring safe and nurturing care in the home.
- The department relies on parents in helping to ensure quality care. Because care is provided in the home, parents have a greater opportunity to observe and evaluate the home setting.
- The department knows that the standards should address critical areas of health, safety, and well-being.
- The department also knows that you need and deserve clear and reasonable standards.

John H. Winters Human Services Center • 701 West 51st Street
Central Office Mailing Address P.O. Box 149030 • Austin, Texas 78714-9030
Telephone (512) 450-3011 • Call your local DHS office for assistance.

Throughout the development of these standards, we have asked for and received involvement from caregivers, parents, and others who are interested in and knowledgeable of child care in the family home. Many people have been helpful in our efforts to develop reasonable standards. The department appreciates your help and support in a mutual goal of ensuring safe child care for Texas children.

Sincerely,

Ronald L

Ron Lindsey

Attachment

INTRODUCTION

Minimum Standards

With the assistance of parents, lawyers, doctors, child care professionals, and experts in fire, sanitation, and safety, ***Minimum Standards for Registered Family Homes*** were developed by the Texas Department of Human Services. The child care licensing law sets guidelines for what must be included in the standards and requires that minimum standards be reviewed and commented on by the State Advisory Committee on Child Care Facilities. The department considers recommendations from caregivers, other interested individuals, and groups in formulating the final standards. Standards are a product of input from many people and groups and are designed to reflect what the citizens of Texas consider reasonable and minimum. If a caregiver or other person has questions about the standards or registration process, she should call the nearest licensing office for assistance and information.

Exceptions to Minimum Standards

A **variance** is a department decision allowing a caregiver to comply with a specific standard in a way that meets the intent of the standard but is different from the usual compliance, as long as the health, safety, and well-being of the children are reasonably protected.

A **waiver** is a department decision allowing a caregiver **not** to comply with a specific standard if department staff determine that the possibility of risk is not significantly increased, and that the economic impact of compliance is great enough to make compliance impractical.

A caregiver may request a waiver or variance when applying for registration or during the time the home is regulated. Regional licensing staff receive the request and recommends a decision to state office licensing staff. The final decision concerning the request for a waiver or variance is made in the state office primarily by considering the risk to the health, safety, and well-being of the children in care. Waivers and variances are time-limited.

Administrative Reviews

An applicant or a registered caregiver has the right to request an administrative review if she disagrees with a licensing representative's decision or action. Caregivers are encouraged to first talk over the situation with the licensing representative and the representative's supervisor. If this does not solve the problem, a caregiver may contact the day care licensing supervisor or the regional director for day care licensing in the area. The licensing representative provides the name, address, and telephone number of the person to contact. The caregiver may request the review orally or in writing. She describes the decision or action in dispute and identifies the issues. The department's licensing staff conducts the review. The reviewer examines the facts and then recommends/decides to uphold or change the licensing representative's decision. The caregiver is promptly informed of the decision.

Appeals and Court Challenges

If the department denies a registration request or revokes a registration, the caregiver is notified in writing which standards or provisions of the law are being violated. She is given information about how to request an appeal. The caregiver may request an appeal of the decision within 30 days of notification. If the director of licensing grants a request for an appeal, the department's general counsel designates an administrative law judge to conduct the appeal and notify the appellant of the department's final decision. If a person who appeals a denial or revocation does not agree with the decision on the appeal, she may challenge it within 30 days after notification of the decision. This is done by filing suit in a district court in Travis County or in the county where the registered home is located.

MINIMUM STANDARDS FOR REGISTERED FAMILY HOMES

In a registered family home, the caregiver

- takes care of children in her home; and
- takes care of no more than six children under age 14, plus no more than six additional school-age children. The total number (counting her own) is no more than 12 at any time. (See the chart in Standard 2100 for the maximum number based on the ages of the children.)

If the caregiver takes care of more than three children (besides her own), the home must be registered with the Department of Human Services. A person caring for three or fewer children may request registration.

MINIMUM STANDARDS FOR REGISTERED FAMILY HOMES

Page

1000 THE CAREGIVER AND FAMILY **1**

1100 Caregiver Qualifications 1
1200 People in the Home 2

2000 THE CHILDREN IN CARE **3**

2100 The Number of Children in Care 3
2200 Admission Requirements 4

3000 HEALTH AND SAFETY **5**

3100 Fire Prevention, Sanitation, and Safety 5
3200 Nutrition 5
3300 Telephone 5
3400 Accidents and Illnesses 6

4000 CHILD CARE IN THE REGISTERED FAMILY HOME **7**

4100 Supervision 7
4200 Abuse or Neglect of Children in Care 7
4300 Activities 7
4400 Discipline 7

GLOSSARY **8**

APPENDICES

APPENDIX I 9
Immunization and Tuberculosis Test Requirements

APPENDIX II 11
Fire Prevention

APPENDIX III 13
Sanitation

APPENDIX IV 15
Safety

APPENDIX V 17
Water Activities

APPENDIX VI 19
Transportation

Page

APPENDIX VII 21
Kinds and Amounts of Foods to be Served
to Meet Nutritional Needs

APPENDIX VIII 23
Criminal Offenses from the Texas Penal Code

GUIDELINES

GUIDELINES I 25
Enrollment

GUIDELINES II 27
Fire Prevention

GUIDELINES III. 29
Sanitation

GUIDELINES IV 31
Safety Checklist

GUIDELINES V. 33
Examples of Kinds of Foods
to be Served to Meet Nutritional Needs

GUIDELINES VI 39
Medications

GUIDELINES VII 41
Alternatives to Physical Punishment

GUIDELINES VIII 43
Substitute Caregiver

GUIDELINES IX. 45
Sanitizing Procedures for Food Service Equipment

GUIDELINES X. 47
Communicable Disease Chart for Schools and Child-care Centers

SAMPLE FORMS

(Reserved for future use.)

THE CAREGIVER AND FAMILY

1100 Caregiver Qualifications

1. A caregiver requesting registration must be at least 21 years old.
   [**Exception:**] A person who is 18 through 20 years old may be the caregiver if she has
   a. a child development associate credential,
   b. an associate of arts in child care,
   c. a community or junior college certificate in child care,
   d. an accreditation or credential recognized by the licensing branch, or
   e. documentation of satisfactory completion of a course of study recognized by the licensing branch. The course may be correspondence, self-instructional material, workshop, college hours, or home economics cooperative education in child development. Persons qualifying under this paragraph, however, must also have at least nine months experience in registered or licensed day care.

2. Caregivers requesting registration must have a certificate of completion of the department's orientation in health, safety, and sanitation related to preventing risk to children in care. This does not apply to caregivers registered by July 1, 1990.

3. Caregivers requesting registration must have a high school diploma or Texas Certificate of High School Equivalency (GED) or similar credential. This does not apply to caregivers registered by July 1, 1990.

4. The caregiver must display the registration certificate in a prominent place where parents and others may see it.

5. The caregiver must have and maintain
   a. a current certificate indicating successful completion of a course in first aid; and
   b. a current certificate indicating successful completion of a course in cardiopulmonary resuscitation of infants and children.

6. Each year the caregiver must obtain 20 clock hours of training chosen from the following fields:
   a. child development, discipline and guidance, nutrition, age and developmentally appropriate activities;
   b. sanitation, health, and safety; and
   c. business management, risk reduction/risk management, communication with peers and other professionals, parent involvement, and utilizing community resources.

7. A person who takes care of the children when the caregiver is gone must be 18 years old and able to ensure the safety of the children [see Guidelines VIII, **Substitute Caregiver**]. A person who is 14 through 17 years old may help but must never be left alone with the children.

1200 People in the Home

1. When children are present, people whose behavior or health endangers the health, safety, or well-being of the children must not be in the registered family home. Caregivers, family members, visitors, parents, or other people with symptoms of a contagious disease, a physical or mental condition that would be harmful to the children, or who appear to be under the influence of alcohol or other drugs must not be in the home when children are present.

2. When children are present, a person who has been convicted of any of the following offenses is not allowed in the home and must not be in contact with the children while in care [see Appendix VIII, **Criminal Offenses from the Texas Penal Code**]:

    a. felony or misdemeanor classified as an offense against the person or the family,

    b. felony or misdemeanor classified as public indecency,

    c. felony violation of any law intended to control the possession or distribution of any substance included as a controlled substance in the Texas Controlled Substances Act.

3. Until charges are dropped, a person who is indicted for any of the offenses listed in [Standard 1200,2] or who is the subject of an official criminal complaint (related to those offenses) that has been accepted by a county or district attorney must not be in the home or have contact with the children while the children are in care.

    The department must be notified of the indictments or complaints within 24 hours of awareness or by the next workday.

4. The caregiver must submit a completed criminal history information form for any new caregiver, substitute, or adult resident of the home within two weeks after that person begins the new role.

5. When children are present, a person who is over 14 years old and in the home must have a record of a tuberculosis examination indicating that the person was free of tuberculosis disease. The examination must have occurred within 12 months before the date the home was first registered with the department or within 12 months before the individual comes to the home. If the local health authority or the regional office of the Texas Department of Health recommends further examinations, the caregiver must comply. The caregiver must keep a copy of the examination records in the home.

6. People must not smoke in the home during hours of operation.

THE CHILDREN IN CARE

2100 The Number of Children in Care

The maximum number of children the caregiver may care for in a registered family home is determined by the ages of the children [see chart, Limits on Numbers of Children in Care by Age, in this standard]. The caregiver must count all children present, including her own.

If more than six children are present in the home, the children in excess of six must be school-age children in care. After school hours also include school holidays, summer vacations, and periods during which the school is in operation but students are not expected to attend [such as teacher workdays].

School-age children are those whose ages are 5 through 13 and who regularly attend school in addition to the registered family home.

There must not be more children in the home at the same time than is shown in one of the lines across the chart.

Limits on Numbers of Children in Care by Age

Infants 0-17 mos.	Preschoolers 18 mos. and older	School Age Children 5-13 yrs.	Maximum Allowed
0	6	6	12
0	5	7	12
0	4	8	12
0	3	9	12
0	2	10	12
0	1	11	12
0	0	12	12
1	5	4	10
1	4	5	10
1	3	6	10
1	2	7	10
1	1	8	10
1	0	9	10
2	4	2	8
2	3	3	8
2	2	4	8
2	1	5	8
2	0	6	8
3	3	1	7
3	2	2	7
3	1	3	7
3	0	4	7
4	2	0	6
4	1	1	6
4	0	2	6

2200 Admission Requirements

When accepting a child for care, the caregiver must comply with the following admission requirements:

1. The caregiver must obtain and keep
   a. current immunization records and tuberculosis test reports for each child in the home including her own children's records [see Appendix I, **Immunization and Tuberculosis Test Requirements**].

   b. telephone numbers at which parents may be reached while child is in care.

   c. emergency medical authorization [see Guidelines I, **Enrollment**, for other enrollment information].

2. The caregiver must review with parents and give them a copy of the Texas Department of Human Services' **Parents' Guide to Registered Family Homes** and obtain a signed receipt. The caregiver keeps the receipt as long as that child is in her care [see Guidelines I].

3. The caregiver must not refuse to care for a child because of race.

4. On a 24-hour basis, care for a child must not exceed 30 days at any one time and no more than 45 days per year.

HEALTH AND SAFETY

3100 Fire Prevention, Sanitation, and Safety

1. The caregiver must keep the home, indoors and out, free of hazards and otherwise safe and healthy for children [see Appendices II, III, and IV and Guidelines II, III, and IV].

2. If there is a swimming pool, wading pool, pond, creek, or other body of water on or near the premises of the home, the caregiver must ensure that children are protected from unsupervised access to the water [see Appendix V, Items 1-3, **Water Activities**]. If the caregiver allows children in care to participate in water activities, she must follow the requirements in [Appendix V].

3. If providing transportation, the caregiver must transport each child in an infant carrier, child seat, or a seat belt as appropriate to the child's age and size [see Appendix VI, **Transportation**].

4. When taking the children away from the home, the caregiver must take the children's emergency medical forms and emergency contact information, and first aid supplies [see Standard 3400,2, **Accidents and Illnesses**].

3200 Nutrition

The caregiver must ensure that the children in care have nutritious meals and snacks in adequate amounts as shown in [Appendix VII, **Kinds and Amounts of Foods To Be Served To Meet Nutritional Needs**. See also Guidelines V, **Examples of Kinds of Foods To Be Served To Meet Nutritional Needs and Sample Meal Pattern**].

3300 Telephone

The registered family home must have

1. a working telephone; and

2. the following telephone numbers posted near the telephone:
   a. ambulance service or emergency medical services (EMS),
   b. local police or sheriff's department,
   c. fire department,
   d. local poison control center,
   e. local DHS Licensing Office,
   f. each child's telephone number where parents or other designated person may be reached in case of an emergency,
   g. location address and telephone of caregiver; and
   h. child abuse hot line.

3400 Accidents and Illnesses

The following requirements pertain to the prevention of accidents in the registered family home:

1. If the caregiver is not present while children are in care, an adult certified in CPR must be at the home and available to intervene in an emergency.

2. The caregiver must keep first aid supplies readily available in a designated location but out of the children's reach. She must keep a guide to first aid emergency care accessible at all times. [First aid supplies include at least multi-size adhesive bandages, gauze pads, tweezers, cotton balls, hydrogen peroxide, syrup of ipecac, and a thermometer.]

3. The caregiver is allowed to give medicine to a child in care only if a physician or the child's parents have given written permission and instructions [see Guidelines VI, **Medication**].

4. If a child gets sick or is injured, the caregiver must notify the child's parents at once. If the illness or injury is serious, the caregiver must call the physician listed on the emergency care form, take the child for emergency care, or call for emergency transportation.

4100 Supervision

Children must be supervised

1. at all times by an adult who is able to take care of them; and
2. in a way that ensures that the caregiver is aware of what the children are doing at all times and can assist or redirect activities when necessary. In deciding how closely to supervise the children, the caregiver must think about the following points:
   a. age of the children;
   b. individual differences and abilities;
   c. layout of the house and play area (floor plan, arrangement, intercoms, established boundaries); and
   d. neighborhood circumstances, hazards, and risks.

4200 Abuse or Neglect of Children in Care

1. Children must not be abused or neglected while in the registered family home.
2. If a child appears to be abused or neglected when he comes to the home, the caregiver must call the nearest Department of Human Services Child Protective Services Office or the local or state law enforcement agency immediately as required in Chapter 34 of the Texas Family Code, Reporting of Child Abuse. This law provides immunity to anyone who makes a good faith report.
3. The caregiver must display in a prominent place a sign explaining the requirement to report abuse or neglect. This sign is required by law. The department provides the sign.

4300 Activities

1. The caregiver must provide regular indoor and outdoor activities appropriate to the developmental needs of the children. The caregiver must include quiet and active play and make available sufficient toys and equipment that are appropriate for the developmental stages of children in care.
2. The caregiver must provide appropriate activities for infants outside their cribs for periods of time during each day.

4400 Discipline

Children in care must not be punished cruelly, harshly, or in an unusual way. A child of any age must never be shaken or hit. A child under five years old must never be spanked. If the child's parents give signed permission, the caregiver is allowed to spank only a child five years old or older. Only an open hand may be used to spank, and the caregiver may spank only the child's buttocks [see Guidelines VII, Alternatives to Physical Punishment].

GLOSSARY

Glossary

Own children — The caregiver's children by birth, adoption, marriage, or conservatorship [see Standard 1100, **Caregiver Qualifications**].

Parent — A biological or adoptive mother or father, legal guardian, or a managing conservator.

School-age children — Children whose ages are 5 through 13 and who regularly attend school in addition to the registered family home.

Self-instructional material — Material that is designed with specifically stated objectives, curriculum, activities, and evaluation as design components of the material. Self-instructional material is designed to be used by one individual and has a means of evaluation to determine whether the person who has used the self-instructional material has obtained the information necessary to meet the stated objectives.

Training — Time spent in workshops; conferences of registered family home, early childhood, or educational associations; formal schooling; self-instructional material; or planned learning opportunities provided by consultants.

MINIMUM STANDARDS FOR REGISTERED FAMILY HOMES

APPENDICES

Page

APPENDIX I 9
Immunization and Tuberculosis Test Requirements

APPENDIX II.. 11
Fire Prevention

APPENDIX III.. 13
Sanitation

APPENDIX IV 15
Safety

APPENDIX V 17
Water Activities

APPENDIX VI 19
Transportation

APPENDIX VII 21
Kinds and Amounts of Foods to be Served
to Meet Nutritional Needs

APPENDIX VIII 23
Criminal Offenses from the Texas Penal Code

APPENDIX I
IMMUNIZATION AND TUBERCULOSIS TEST REQUIREMENTS

1. Ensure that each child's immunization record includes the child's birth date, the number of doses and types, and the dates (month, day, and year) the child received each immunization. Compliance with this requirement is measured by one or more of the following for each child in care, including your own:

   a. A dated record that the child has been immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, and rubella. There must be a

      (1) record with a rubber stamp or signature of the physician or health specialist.

      (2) machine or handwritten copy of the immunization record. If you copy the information, sign the handwritten copies.

   b. A dated statement from a licensed physician or other authorized health specialist that immunizations against at least one of the diseases have begun. The immunization cycle must be completed as soon as is medically feasible. The center must have a current immunization record on file.

   c. A certificate signed by a licensed physician stating that the required immunization would be injurious to the health and well-being of the child or a member of the child's family or household.

   d. An affidavit (notarized statement) signed by the parent that the immunization conflicts with the parent's religious beliefs and practices.

   e. A dated statement signed by the parent that the child's immunization record is current and is on file at the school the child attends (include the name of the school in the statement).

   See the chart on page 10 for the required immunizations by age group.

2. An Annual Report of the Immunization Status of all children by age group must be submitted on the request of the Texas Department of Health. Age groups must conform to the categories in the table entitled Required Immunizations by Age Group.

3. If the local health authorities or the regional office of the Texas Department of Health recommends testing for tuberculosis, keep a record showing that each child has been tested according to recommendations.

   A dated statement signed by the parent that the child's tuberculosis test record is current and is on file at the school the child attends also complies with the requirement. The name of the school must be in the statement.

REQUIRED IMMUNIZATIONS BY AGE GROUP

Age Group	Cumulative Immunization Required
Under 2 mos.	No immunizations required
2 mos. to 4 mos.	1 dose of oral polio vaccine (OPV) 1 dose of diphtheria-tetanus-pertussis (DTP) vaccine
4 mos. to 6 mos.	2 doses of OPV 2 doses of DTP vaccine
6 mos. to 18 mos.	2 doses of OPV 3 doses of DTP vaccine
18 mos. to 5 yrs.	3 doses each of OPV and DTP vaccine 1 dose each of measles(1), rubella(2), and mumps(3) vaccines
5 yrs. and older	3 doses each of OPV(4) and DTP(5) vaccine 1 dose each of measles(1), rubella(2), and mumps(3) vaccines

NOTES:

(1) **Measles:** Measles vaccine is required for each child 18 months old or older. The vaccination date for the measles vaccine must be during the calendar month of or after the first birthday. An acceptable substitute is a written physician-verified history of measles disease, which shows the date of the illness.

(2) **Rubella:** A history of rubella illness is not an acceptable substitute for the vaccine. Rubella vaccine is not required after the 12th birthday.

(3) **Mumps:** Children are required to have received mumps vaccine or provide a physician-verified history of mumps illness.

(4) **Polio:** At least three doses of oral polio vaccine (OPV) are required, provided at least one dose has been received on or after the fourth birthday. A dose of OPV given during the calendar month before the fourth birthday will substitute for the dose on or after the fourth birthday. No further doses of OPV are required.

Some children may have received inactivated polio vaccine (IPV). These children are in full compliance when an initial series of four doses are completed and a booster dose within five years of the fourth dose has been received. A booster dose is required every five years thereafter. If the child, upon advice, starts receiving OPV, total requirement for OPV must be met.

(5) **Diphtheria-Tetanus-Pertussis/Tetanus-Diphtheria:** At least three doses of DTP and/or Td vaccine are required, provided at least one dose has been received on or after the fourth birthday. A dose of DTP or Td given during the calendar month before the fourth birthday will substitute for the dose on or after the fourth birthday.

In addition to the minimum of three DTP or Td Doses with one dose since the fourth birthday, children 12 years of age and older must have a last dose within the past 10 years.

APPENDIX II
FIRE PREVENTION

1. In case of danger of fire, get the children to safety. Safety of the children is your first responsibility. You must have plans and procedures for fire and other emergencies (for example, tornado, hurricane, explosion, toxic leak) and you must practice them every six months.

2. Ensure that electrical wiring system, fuses or circuit breakers, and cords for electrical appliances and lighting fixtures are in safe condition.

3. Have a qualified technician inspect the central heating units as often as recommended by the manufacturer.

4. Enclose wood-burning or gas-log fireplaces with a spark screen or guard. Safeguard floor and wall furnace grates and space heaters with a rigid screen or guard so that children do not have access to hot surfaces. Open-flame space heaters are not permitted. Enclose space heaters and display the seal of approval of a test laboratory approved by the fire marshal.

5. Ensure that liquid or gas fuel heaters are vented properly to the outside.

6. Equip your home with one or more smoke detectors and place and maintain them according to the manufacturer's instructions.

7. Have a 40 BC rated dry chemical fire extinguisher in good working condition in the kitchen. The top of the extinguisher must be no higher than five feet above the floor and the bottom at least four inches above the floor or any other surface. The fire extinguisher must be serviced after each use and checked for proper weight at least once a year. When children are in care, there must be an adult present who knows how to operate the fire extinguisher.

8. Ensure that at least two unblocked exits to the outside of the home are available. (Count a window as an exit if children can get through it to the ground outside of the house safely and quickly.)

APPENDIX III
SANITATION

To ensure compliance with all of the sanitation requirements,

1. use either a public water supply or a private well that is approved by local health authorities or the Texas Department of Health.

2. use either a public sewage disposal system or a private system that is approved by local health authorities or the Texas Department of Health.

3. provide running water in the home.

4. provide at least one flush toilet and one lavatory inside the home.

5. wash hands with soap and running water after using the toilet and before eating. You and the children must follow this requirement. You must wash your hands with soap and running water before and after changing a diaper, assisting a child with toileting, feeding a child or handling food, and caring for a child with symptoms of a communicable disease.

APPENDIX IV
SAFETY

To ensure compliance with the safety requirements,

1. keep cleaning supplies, bug sprays, medicines, and other materials that would harm children where children cannot reach them.

2. ensure that animals on the premises have been vaccinated according to a licensed veterinarian's recommendation. Keep documentation of the vaccinations and recommendations. Keep your home and yard free of stray animals. Do not allow children to play with stray animals or with other animals that could be dangerous.

3. immediately notify the local Department of Human Services licensing office of any serious occurrences affecting the operation of your home. These include, but are not limited to, the following:

   a. fire; and

   b. death, serious accident, serious injury, or serious communicable disease of a child or staff.

   At a minimum, consider a "serious accident" or "serious injury" to be one that causes a child or staff to see a physician for emergency care, or one that should have caused a child to see a physician. "Serious communicable disease" includes at least all immunization-preventable illnesses, other communicable illnesses for which a child is hospitalized, and other illnesses the general public considers serious.

4. do not allow toys that explode (such as caps) or that shoot things (such as darts and BBs). Do not allow toys that contain poisonous materials (such as lead paints or poisonous gases).

5. ensure that all swing seats are constructed of durable, lightweight, relatively pliable material, such as rubber or nylon webbing.

6. ensure that children are not allowed to

   a. climb on equipment or swings that are located on concrete or asphalt.

   b. use swings or other equipment with concrete or asphalt in the fall zone. Consider the fall zone to be an area extending four feet from climbing structures; five feet from the bottom of a slide (other parts of the slide are climbing structures); seven feet plus the length of the chain from a swing's point of suspension; and seven feet from a merry-go-round and other revolving device.

7. ensure that no equipment has openings or angles that could entrap a child's head. Entrapping equipment is a component or group of components on play equipment that forms angles or openings that could trap a child's head by being
    a. too small to allow the child to withdraw his head easily.
    b. placed so that the child would be unable to support his weight by means other than his head or neck.

8. ensure that equipment or underneath equipment has no pinch, crush, or shear points (such as exposed, open gears on rotating devices or axle assemblies on rotating devices).

APPENDIX V
WATER ACTIVITIES

1. If you have a splashing or wading pool less than two feet deep
   a. drain and clean the pool after each use; and
   b. store portable pools where children cannot reach them when not in use.

2. If a swimming pool or other body of water is located at or near your home, take the necessary precautions to ensure that children cannot gain unsupervised access.

3. If the pool is located in an apartment complex, assure that outside play activities are not conducted near the pool unless the pool or playground is enclosed by a fence to ensure that children cannot easily gain access to the pool.

4. When the children use a splashing or a wading pool with less than two feet of water, there must be present at least the number of adults indicated in the following table:

Age of Youngest Child in Group	Number of Adults		Maximum Number of Children
6 months-23 months	1		1
		or	
	2		6
2 years	1		6
3 years	1		6
4 years and older	1		12

5. If you allow the children to use the body of water (two ft. deep or deeper), an adult certified in water safety must supervise the children at all times. Acceptable certifications include a current life saving, water safety, or lifeguard-type certificate of training in water safety by a qualified instructor and under reputable sponsorship. **In addition to the lifeguard**, an adequate number of adults must be present to supervise the children to meet the following ratios:

Age of Youngest Child in Group	Number of Adults		Maximum Number of Children
6 months-23 months	1		1
2 years or older	1		3
		or	
	2		4 or more

6. Keep at least one life-saving device available.

7. Ensure that pool chemicals are stored out of the reach of children.

APPENDIX VI
TRANSPORTATION

"Appropriateness" as stated in Standard 3100,3, **Fire Prevention, Sanitation, and Safety**, is determined as follows:

a. Ensure that an infant who cannot sit up without support is properly restrained in a dynamically crash-tested infant carrier designed as a child passenger restraint device and manufactured according to federal standards. The carrier must be placed in a semi-reclining position facing the back of the car. The carrier must be held in the seat by the standard fixed seat belt.

b. Ensure that each child under two years who can sit alone is properly seated in a child seat that is a dynamically crash-tested child passenger restraint device manufactured according to federal standards.

c. Ensure that each child age two or older is either restrained by a seat belt or rides in a child seat that is a dynamically crash-tested child passenger restraint device manufactured according to federal standards. Only one person may use each seat belt.

d. A child may ride in a shoulder harness and seat belt if the shoulder harness goes across the child's chest and not across the child's face or neck.

e. You must properly anchor each restraint device and use the device according to the manufacturer's specifications.

f. Do not allow a child to ride in the open back of a pick-up truck.

APPENDIX VII
KINDS AND MINIMUM AMOUNTS OF FOODS TO BE SERVED TO MEET NUTRITIONAL NEEDS OF CHILDREN

Kinds of Food	Total Amount to Meet 1/2 of Minimum Daily Need for Children Ages:		
	1-3	4-6	7 and Older
1. Milk Group			
Milk or	1 1/2 cups	1 1/2 cups	1 1/2 cups
Cheese	2 1/4 ounces	2 1/4 ounces	2 1/4 ounces
Other servings which equal 1/2 cup of milk are 1/2 cup yogurt or 1 cup of cottage cheese.			
2. Grain Group			
Bread or	2 slices	2 slices	2 slices
Cereal	1 cup	1 cup	1 cup
Other servings which equal 1 slice of bread: 1 oz. ready-to-eat cereal, 1/2 cup pasta, 1/2 cup rice, or 1/2 cup grits.			
3. Vegetables and Fruit			
Including 1/4 cup vitamin C-rich fruit or vegetable each day and	3/4 cup	1 cup	1 1/4 cup
1/4 cup vitamin A-rich fruit or vegetable 3 times each week			
4. Meat Group			
Meat, Fish, Poultry (cooked) or	2 tablespoons 1 ounce	3 tablespoons 1 1/2 ounce	3 tablespoons 1 1/2 ounce
Eggs or	1 egg	1 egg	1 egg
Cooked dried Beans or Peas or	1/4 cup	3/8 cup	3/8 cup
Cheese	1 ounce	1 1/2 ounce	1 1/2 ounce
One tablespoon peanut butter can be substituted for 1 tablespoon of meat			

APPENDIX VIII
CRIMINAL OFFENSES FROM THE TEXAS PENAL CODE

The following constitute criminal offenses included in the *Texas Penal Code:*

Title 5. Offenses Against the Person

Murder
Capital murder
Voluntary manslaughter
Involuntary manslaughter
Criminally negligent homicide
False imprisonment
Kidnapping
Aggravated kidnapping
Rape
Aggravated rape
Sexual abuse
Aggravated sexual abuse
Homosexual conduct
Public lewdness
Indecent exposure
Rape of a child
Sexual abuse of a child
Indecency with a child
Assault
Sexual assault
Aggravated assault
Aggravated sexual assault
Deadly assault on a peace officer
Injury to a child or an elderly individual
Reckless conduct
Terroristic threat
Aiding suicide
Tampering with consumer products

Title 6. Offenses Against the Family

Bigamy
Incest
Interference with child custody
Enticing a child
Criminal nonsupport
Sale or purchase of a child
Solicitation of a child
Harboring a runaway child
Violation of a court order

Title 43. Public Indecency

Prostitution
Promotion of prostitution
Aggravated promotion of prostitution
Compelling prostitution
Obscene display or distribution
Obscenity
Sale, distribution or display of harmful material to a minor
Sexual performance by a child

MINIMUM STANDARDS FOR REGISTERED FAMILY HOMES

GUIDELINES

Page

GUIDELINES I 25
Enrollment

GUIDELINES II 27
Fire Prevention

GUIDELINES III 29
Sanitation

GUIDELINES IV 31
Safety Checklist

GUIDELINES V 33
Examples of Kinds of Foods
to be Served to Meet Nutritional Needs

GUIDELINES VI 39
Medications

GUIDELINES VII 41
Alternatives to Physical Punishment

GUIDELINES VIII 43
Substitute Caregiver

GUIDELINES IX 45
Sanitizing Procedures for Food Service Equipment

GUIDELINES X 47
Communicable Disease Chart for Schools and Child-care Centers

GUIDELINES I
ENROLLMENT

1. Before enrolling a child, inform parents about the home's activities and policies.

2. Obtain enrollment information for each child before admission. Keep this information while the child is in care. Require that a parent sign a form that contains the following:

   a. child's name, birthdate, home address, and home telephone number;

   b. name and telephone number of the school a school-age child attends;

   c. date of admission;

   d. name and address of parent(s) and telephone numbers at which parent(s) can be reached while the child is in care;

   e. names of people to whom the child may be released;

   f. hours the child will be in care;

   g. permission for transportation or trips away from the home;

   h. permission for participation in water activities, if any;

   i. name, address, and telephone number of the child's physician;

   j. emergency medical authorization; and

   k. statement of the child's special problems or needs. This includes allergies, existing illness, previous serious illness and injuries, hospitalizations during the past 12 months, and any medication prescribed for long-term, continuous use. Ensure that children who need special care in the home because of disability or limiting conditions are given the care and activities that qualified psychologists, physicians, or other experts recommend.

GUIDELINES II
FIRE PREVENTION

1. When developing plans and procedures for fire and other emergencies, consider the abilities and limitations of each child in care.
2. Do not overload extension cords. Do not run the cords under rugs or through door openings. Do not hook cords over nails.
3. Ensure that all gas tubing and connections for appliances (heaters, water heaters, stoves) are metal.
4. If trash must be burned, burn it in an area away from the children.
5. Do not leave lighters and matches where children can reach them.
6. Keep flammable liquids in safety cans where children cannot reach them. Keep cans away from all heat sources.
7. Keep your home, attic, basement, garage, and storage shed free of combustible rubbish.
8. Keep rags, paper, and other combustible materials from heat.
9. Have a five-pound ABC fire extinguisher mounted to a wall in a place near an exit. The top of the extinguisher must be no higher than five feet above the floor and the bottom must be at least four inches above the floor or any other surface. The fire extinguisher must be serviced after each use and checked for proper weight at least once a year. When children are in care, there must be an adult present who knows how to operate the fire extinguisher.

GUIDELINES III
SANITATION

To ensure the children's health, follow these guidelines:

1. Keep your kitchen and all food preparation, storage, and serving areas and utensils clean.
2. Refrigerate or safely store perishable foods.
    - dry products 32°-85°F
    - frozen products 0°F or below
    - refrigerated products 36°-40°F
3. Keep garbage in metal or plastic containers with tight-fitting lids in an area away from the children. You may use tightly closed garbage bags. Remove garbage from your home daily. Ensure that garbage is removed weekly from your property.
4. Maintain plumbing in good working condition.
5. Keep the bathroom clean and daily sanitized.
6. Keep your yard well drained, with no standing water.
7. Use screens on windows and outside doors that are kept open.
8. Take necessary steps to ensure your home is free of insects, mice, and rats.
9. Keep your house adequately clean and ventilated.
10. If children use washcloths or cloth towels, ensure that each child has a clean, individual cloth. If paper towels or facial tissues are furnished, provide a clean individual-use paper towel for each child.
11. Ensure that any linens on children's mats, cots, or beds are clean.
12. Defrost foods in refrigerator, not at room temperature.
13. Do not leave cooked foods at room temperature for longer than 45 minutes.

GUIDELINES IV
SAFETY CHECKLIST

To ensure the children's safety, follow these guidelines:

1. Provide safe, indoor and outdoor toys, equipment, and supplies for the children.
2. Provide safety electric outlets or use child-proof covers in rooms used by children younger than five years old.
3. Mount electric fans securely where children cannot reach them, or provide guards to keep children from touching the fan blades.
4. Ensure that outdoor floors and steps are not slippery. Porches, railings, playhouses, and other wooden structures must not have splinters.
5. Ensure that indoor floors and steps are not slippery. Floors must be dry when the children are using them, and wood surfaces and objects must not have splinters.
6. Mark glass doors at a child's eye level to prevent accidents.
7. Install all heavy equipment to prevent tipping over or collapsing.
8. Ensure that any firearms in the home are securely locked away from the child care area. Keep ammunition locked in a place separate from guns.
9. Ensure that any locking doors between rooms used for child care can be easily unlocked.
10. Ensure that hot water available to children is not hotter than 120°F.

GUIDELINES V
EXAMPLES OF KINDS OF FOODS TO BE SERVED TO MEET NUTRITIONAL NEEDS

(These may differ from the federal reimbursement requirements)

1) Milk group supplies these key nutrients: Calcium, riboflavin (vitamin B2) and protein for strong bones and teeth, healthy skin, and good vision. It is best to serve fluid milk, lowfat and regular cheeses, and lowfat and regular yogurt to meet the milk requirement. Children over two years of age may be offered lowfat milk products. Children from birth through 11 months should be encouraged to consume breast milk supplied by the mother. See "guidelines for infants."

Milk	**Cheese***	**Yogurt**
Whole	Cheddar	Commercial yogurt, regular, lowfat, plain, or flavored
Low Fat	American	
Skim	Cottage+	
Non Fat Dry	Monterey Jack	
Buttermilk	Swiss	
	Mozzarella	
	Ricotta+	

+Double serving is required.
*Do not count the same slice of cheese as both milk and meat.

2) Vegetable and fruit groups supply these key nutrients: vitamins A and C for night vision and to help resist infections and to heal wounds.

a) Vitamin A Foods

Vegetables and fruits, 1/4 cup serving (about 1,500 or more international units of vitamin A)

Beet greens
Carrots
Chard, swiss
Chili peppers, red
Collards
Cress, garden
Dandelion greens
Kale
Mangoes
Mixed vegetables
Mustard greens
Peas and carrots (canned or frozen)
Peppers, sweet red
Pumpkin
Spinach
Squash, winter (acorn, butternut, Hubbard)
Sweet potatoes
Turnip greens

1/4 cup serving (about 750-1,500 international units of vitamin A)

Apricots
Broccoli
Cantaloupe
Chicory greens
Papayas
Purple plums (canned)

1/2 cup serving (about 750-1,500 international units of vitamin A)

Asparagus, green
Cherries, red sour
Chili peppers, green (fresh)
Endive, curly
Escarole
Nectarines
Peaches (except canned)
Prunes
Tomatoes
Tomato juice or reconstituted paste or puree

The vegetables and fruits listed supply at least 750 international units of vitamin A per 1/4 or 1/2 cup serving. When these vegetables and fruits are served at least three times a week in recommended amounts along with a variety of additional vegetables and fruits used to meet the vegetable and fruit requirement, the vitamin A content generally meets 1/2 of the recommended dietary allowance for each age group.

b) Vitamin C Foods

1/4 cup serving (about 25 milligrams or more of vitamin C)

- Acerola
- Broccoli
- Brussels sprouts
- Chili peppers, red and green
- Guavas
- Orange juice
- Oranges
- Papayas
- Peppers, sweet red and green

1/4 cup serving (about 15-25 milligrams of vitamin C)

- Cauliflower
- Collards
- Cress, garden
- Grapefruit
- Grapefruit juice
- Grapefruit-orange juice
- Kale
- Kohlrabi
- Kumquats
- Mangoes
- Mustard greens
- Pineapple juice (vit. C restored—canned)
- Strawberries
- Tangerine juice
- Tangerines

1/4 cup serving (about 8-15 milligrams of vitamin C)

- Asparagus
- Cabbage
- Cantaloupe
- Dandelion greens
- Honeydew melon
- Okra
- Potatoes (baked, boiled, or steamed)
- Potatoes (reconstituted, instant mashed vit. C restored)
- Raspberries, red
- Rutabagas
- Sauerkraut
- Spinach
- Sweet potatoes (except those canned in syrup)
- Tangelos
- Tomatoes
- Tomato juice reconstituted paste or puree
- Turnip greens
- Turnips

The vegetables and fruits listed supply about eight milligrams or more vitamin C (ascorbic acid) per 1/4 cup serving. When these vegetables and fruits are served daily in recommended amounts along with a variety of additional vegetables and fruits to meet the vegetable and fruit requirement, the vitamin C content generally meets 1/2 of the recommended dietary allowance for each age group.

c) Other Foods

- Apples
- Applesauce
- Avocadoes
- Bananas
- Beans, green or wax
- Bean sprouts
- Beets
- Berries (black, blue, etc.
- Celery
- Chinese cabbage
- Corn
- Cranberries
- Cranberry sauce
- Cucumbers
- Dates
- Eggplant
- Figs
- Fruit cocktail
- Fruits for salads
- Grapes
- Lettuce
- Mushrooms
- Olives
- Onions
- Parsley
- Parsnips
- Peaches (canned)
- Pears
- Peas and carrots (canned)
- Cowpeas, immature seeds
- Pimentos
- Pineapple
- Plums
- Potatoes (mashed, fried, etc.)
- Radishes
- Raisins
- Rhubarb
- Squash, summer
- Watercress
- Watermelon
- Fruit juices (apple grape, pineapple, etc.)

3) Meat/meat alternative group supplies these key nutrients: protein, niacin, iron, and thiamin (vitamin B1) for muscle, bone, and blood cells and healthy skin and nerves.

Meat-canned, dried, fresh, and frozen

Beef
Lamb
Pork
Veal
Luncheon meats
Liver and other organ meats
Chicken
Turkey
Fish/shellfish

Alternate group

*Cheese
Dry beans
Dry peas
Eggs
Lentils
Nuts and seeds (peanuts, almonds, pecans, sunflower seeds, pumpkin seeds cashews)
Vegetable protein (when mixed with meat, poultry, or fish)

*Do not count the same slice of cheese as both milk and meat.

4) Grain group supplies these key nutrients: carbohydrate, thiamin (vitamin B1), iron, and niacin for energy and a healthy nervous system.

All of the following must be enriched or whole grain.

Sliced Breads
French, raisin, rye, soy, white, whole wheat

Bread sticks
Boston brown bread
Fruit breads
Crackers
  graham
  saltines
  soda
  melba toast
  zweiback
Bagels
Rolled wheat or oats
Biscuits
Cornbread
English muffins
Soft pretzels
Croissants
Tortillas
Breakfast cereals, dry or cooked
Pizza crust
Ravioli pasta
Spaghetti
Macaroni
Noodles
Sopapillas
Pancakes
Waffles
Spoon bread
Muffins
Sweet rolls
Barley
Grits
Bulgur
Rolls and buns
Farina
Dumplings
Hush puppies
Rice
Chow mein noodles
Syrian bread (pita)

Serve several good sources of iron each day.

1) Meat and meat alternate

Dry beans and peas
Eggs
Meats in general
  especially liver and
  other organ meats
Peanut butter
Shellfish
Turkey

2) Vegetables and fruits

Apricots (canned)
Asparagus (canned)
Beans—green, wax,
  lima (canned)
Bean sprouts
Beets (canned)
Broccoli
Brussel sprouts
Cherries (canned)
Dried fruits—apples,
  apricots, dates, figs
  peaches, prunes
  raisins
Grapes (canned)
Parsnips
Peas, green
Potatoes (canned)
Sauerkraut (canned)
Squash (winter)
Sweet potatoes
Tomatoes (canned)
Tomato juice, paste
  puree, sauce
Vegetables:
  Dark green
  leafy-beet greens
  chard, collards
  kale, mustard greens
  spinach, turnip
  greens
Vegetable juice (canned)

3) Bread and bread alternate

All enriched or wholegrain bread and bread alternates

The following should be omitted or limited:

Sugar coated cereals
Potato chips
Snack chips
Fruit flavored drinks (use only 100% juice)
Rich pastries and other food high in sugar, fat, and salt
Brownies and cookies with icing
Doughnuts
Coffee
Tea
Soft drinks
Bacon
Sausage
Candy

SAMPLE MEAL PATTERN

The following meal pattern is an aid to menu planning. This distribution of food is not required as long as the total required servings are met during the day.

Possible Food Choices

Breakfast or AM Snack	Milk/Milk Product	1/2 cup
	Bread/Cereal	1 slice or 1 ounce
Lunch	Milk and/or Milk Product	3/4 cup
	Protein	1 1/2 ounces
	Vegetable 1	1/4 cup
	Vegetable 2	1/4 cup
	Bread	1 slice
PM Snack	Fruit or Fruit Juice	1/4 cup

Example Menu Following Meal Pattern

Breakfast or AM Snack	Lunch	PM Snack
Milk	Milk	Orange Juice
Cereal	Roast Beef	
	New Potatoes	
	Spinach	
	Whole Wheat Bread	

GUIDELINES FOR INFANTS

Age of Baby by Month	Breakfast	Lunch	Snack
Birth through 3 months	4-6 fluid ounces (fl. oz.) breast milk or formula[1]	4-6 fl. oz. breast milk or formula	4-6 fl. oz. breast milk or formula
4 months through 7 months	4-8 fl. oz. breast milk or formula 0-3 tablespoons (tbsp.) infant cereal[2] (optional)	4-8 fl. oz. breast milk or formula 0-3 tbsp. infant cereal (optional) 0-3 tbsp. fruit and/or vegetable (optional)	4-6 fl. oz. breast milk or formula
8 months through 11 months	6-8 fl. oz. breast milk, formula, or whole milk 2-4 tbsp. infant cereal 1-4 tbsp. fruit and/or vegetable	6-8 fl. oz. breast milk, formula or whole milk 2-4 tbsp. infant cereal and/or 1-4 tbsp. meat, fish, poultry, egg yolk, or cooked dry beans or peas, or 1-4 oz. cottage cheese, cheese food, or cheese spread, or a 1/2 to 2 oz. of cheese. 1-4 tbsp. fruit and/or vegetable	2-4 fl. oz. breast milk, formula, whole milk, or fruit juice[3] 0-1/2 slice bread or 0-2 crackers[4] (optional)

[1] Iron-fortified infant formula

[2] Iron-fortified dry infant cereal

[3] Full-strength fruit juice

[4] Made from whole-grain or enriched meal or flour

GUIDELINES VI
MEDICATIONS

1. If you agree to administer medications, administer the medication to the child as follows:
   a. Prescription medications should be in the original container labeled with the child's name, date, directions, and the physician's name. Administer the medication as stated on the label directions. Do not administer medication after the expiration date.
   b. Ensure that nonprescription medication is labeled with the child's name and the date the medication was brought to the center. Nonprescription medication must be in the original container. If approved in writing by health personnel or the child's parent (see Glossary), administer medication according to label directions.
   c. Document each dose of medication administered showing the child's name; the name of the medicine; date, time, and amount administered; and the name of the person administering the medicine. Note any missed dosage. Keep record for two weeks.
2. Keep medications out of children's reach or in locked storage.
3. Keep medications requiring refrigeration separate from food.
4. Return medications when no longer needed to the child's parent. Dispose of medications when a child withdraws from the center or when the medicine is out of date.

GUIDELINES VII
ALTERNATIVES TO PHYSICAL PUNISHMENT

1. Children should have good behavior recognized and encouraged.

2. Children should be taught by example and through the use of fair and consistent rules. The atmosphere should be relaxed. Discipline should be relevant to the behavior involved.

3. Children should be supervised by people showing an attitude of understanding and consistency.

4. Children should be given clear directions and guidance on the child's level of understanding.

5. Children should be held firmly if their behavior will harm themselves or others.

6. Children should be redirected by stating and demonstrating alternatives when their behavior is unacceptable. (**Example:** "Blocks are for building, not throwing–try throwing this ball.")

7. Children should be helped to understand why their conduct is unacceptable and what is acceptable in a given situation.

8. Children should be helped to understand that while their behavior may be unacceptable, the child is valued. Children should not be labeled because of their behavior.

9. Children should be redirected or corrected with statements that encourage positive self-esteem.

10. Caregivers may use supervised time-out with children three years old or older.

GUIDELINES VIII
SUBSTITUTE CAREGIVER

Before allowing another adult to take care of children in your home, be sure he understands

1. requirements in the ***Minimum Standards for Registered Family Homes***;
2. policies, including discipline, guidance, and the release of the children;
3. the procedures to follow when handling emergencies. Emergencies include, but are not limited to, fire, explosion, tornado, toxic fume, or other chemical release, and a sick or injured child; and
4. appropriate information about each child, including any specific needs or requirements of children who have disabling conditions, illnesses, or handicaps.

GUIDELINES IX
SANITIZING PROCEDURES FOR FOOD SERVICE EQUIPMENT

Follow one of these methods to wash and sanitize reusable food service equipment, including infant feeding equipment.

1. Completely immerse utensils in hot water and maintain them at a temperature of 170 degrees F for not less than 30 seconds.

2. Use 1 1/4 teaspoon of chlorine bleach for each gallon of water at luke warm temperature during the final rinse. (Water temperature at least 75 degrees F.)

3. Use 1/2 teaspoon iodine for each gallon of water at luke warm temperature during the final rinse for one minute.

4. Use quaternary ammonium compounds or acid sanitizer compounds according to directions on the officially approved label.

5. Ensure that final rinse water is at least 180 degrees F, if utensils are machine washed.

If approved by the local health department or the Texas Department of Health, you may use other methods for sanitizing equipment.

COMMUNICABLE DISEASE CHART FOR SCHOOLS AND CHILD-CARE CENTERS

Your Health Department: ____________________
Phone: ____________________

CONDITION	INCUBATION PERIOD	EARLY SIGNS OF ILLNESS	EXCLUDE FROM ATTENDANCE [1]	READMISSION CRITERIA [1,2]	REPORTABLE DISEASE	NOTES FOR PREVENTION/TREATMENT
AIDS HIV Infection	Variable	Weight loss, generalized swelling of the lymph nodes, failure to thrive, chronic diarrhea, tender spleen and liver Individuals with HIV infection may be asymptomatic	No, unless medical advisor determines that open sores or skin eruptions, behavior (eg, biting), or lack of toilet training pose a risk to others, or when cases of measles, rubella, or chickenpox are occurring in the school	When physician determines, or 2 weeks after the last rash onset of measles or 3 weeks after the last rash onset of chickenpox or rubella occur in the school	Yes	Teach importance of handwashing When cleaning up spills of blood or body fluids wear gloves and use a suitable disinfectant Adolescents should be educated about transmission of the virus through sexual contact and sharing of equipment for injection
Chickenpox	10 21 days	Fever and rash consisting of blisters that may appear first on head, then spread to body Usually 2 or 3 crops of new blisters that heal leaving scabs	Yes	After 7 days from onset of rash, except immunocompromised individuals who should not return until all blisters have crusted over (may be longer than 7 days)	Yes	No vaccine available at this time
Common Cold	1 3 days	Runny nose watery eyes general tired feeling, cough sneezes	No unless fever is present (See Fever)	When fever subsides	No	Teach importance of washing hands and covering mouth when coughing or sneezing
Conjunctivitis Bacterial and/or Viral	1 3 days	Red eyes usually with some discharge or crust on eyelids	Yes	See Footnote 2(A B)	No	Teach importance of handwashing Allergic conjunctivitis is not contagious
Cytomegalovirus (CMV infections)	Unknown under normal circumstances	Usually asymptomatic Congenital CMV infections may result in hearing loss pneumonia, eye inflammation, and growth and/or mental retardation	No		No	Teach importance of good handwashing practices for staff and children Avoid direct contact with urine saliva or other infectious secretions
Diphtheria	2 5 days	Sore throat and fever rapidly progressing to difficulty breathing and swallowing	Yes	See Footnote 2(A B)	Yes	Vaccine available Report suspected cases immediately to local health department and call the Texas Immunization Hot Line 1 800 252 9152
Fever		Oral temperature of 38°C (100 4°F) or greater	Yes	When fever subsides	No	
Fifth Disease (erythema infectiosum)	6 14 days	Redness of the cheeks (slapped face appearance) and body Fever does not usually occur	No unless fever is present (See Fever)	When fever subsides	No	Case should be seen by a physician to rule out a diagnosis of measles
Gastroenteritis Viral	Variable usually 2 7 days	Stomachache, nausea, diarrhea (6 or more watery, loose stools per day) Fever does not usually occur	Yes	When diarrhea subsides	No	Teach importance of handwashing Adult should supervise handwashing of preschool age children
Giardiasis	4 14 days	Gradual onset of stomachache, bloating, and diarrhea May recur several times over a period of weeks	No		No	Treatment is recommended Teach importance of handwashing Can spread quickly in child care facilities
Head Lice (pediculosis)	Eggs hatch in 7 10 days	Itching and scratching of scalp Pinpoint white eggs (nits) that will not flick off the hair shaft	Yes	When one medicated shampoo or lotion treatment has been given	No	Second shampoo or lotion treatment in 7 10 days is recommended Teach importance of not sharing combs, hats, and coats
Hepatitis Viral type A	15 50 days average 28 days	Abrupt onset of fever, tired feeling, stomachache, nausea, or vomiting followed by jaundice Young children may have mild case of diarrhea without jaundice	Yes	After 1 week from onset of illness	Yes	Teach importance of handwashing Immune globulin should be given to household contacts If more than one case occurs in a child care facility, immune globulin should be considered for all children and parents involved
Hepatitis Viral type B	2 6 months	Gradual onset of fever, tired feeling, loss of appetite, followed by jaundice	No		Yes	Vaccine available but recommended for high risk groups only as opposed to the general public Neither cases nor carriers excluded from attendance Teach importance of good hygiene and avoid contact with blood/body fluids of recent cases of chronic carriers
Herpes Simplex (cold sores)	First infection 2 12 days	Blisters, on or near lips, that open and become covered with dark crust Recurrences are common	No		No	Teach importance of good hygiene Avoid direct contact with sores

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Impetigo	Variable, usually 3-7 days	Blisters on skin that open and become covered with yellowish crust. No fever	Yes	When treatment has begun	No	Keep lesions covered while in school. Teach importance of handwashing and keeping fingernails clean
Influenza	1-3 days	Rapid onset of fever, headache, sore throat, cough, chills, lack of energy, muscle aches	Yes	When fever subsides	Yes	Vaccine available, but only recommended for children with certain chronic diseases. Antiviral therapy available for cases of influenza type A
Measles (rubeola)	7-14 days	Runny nose, watery eyes, fever, cough. Blotchy red rash appears on 4th day after prodromal symptoms	Yes	After 4 days from rash onset. In an outbreak, unimmunized children should also be excluded for at least 2 weeks after last rash onset occurs	Yes	Vaccine available. Report suspect cases immediately to local health department and call the Texas Immunization Hot Line 1-800-252-9152
Meningitis, Bacterial	2-10 days	Sudden onset of high fever, headache, and stiff neck, usually with some vomiting	Yes	See Footnote 2(A-B)	Yes	Depending on which bacteria are causing the illness, prophylactic antibiotics may be recommended for family members. Occasionally close contacts at a child care facility are also treated
Meningitis, Viral	2-10 days	Sudden onset of fever, headache, usually with some vomiting	No, unless fever is present (See Fever)	When fever subsides	Yes	Teach importance of handwashing. Prophylactic antibiotics of no value
Mumps	1-26 days, commonly 18 days	Swelling over jaw in front of one or both ears. Pain in cheeks made worse by chewing	Yes	After 9 days from the onset of swelling	Yes	Vaccine available
Pertussis (whooping cough)	7-21 days	Low grade fever, runny nose, and cough lasting about 2 weeks, followed by paroxysmal coughing spells and "whoop" on inspiration	Yes	After completion of 5 days of antibiotic therapy	Yes	Vaccine available. Unimmunized contacts should be immunized and receive antibiotic prophylaxis. Report suspected cases immediately to local health department and call the Texas Immunization Hot Line 1-800-252-9152
Pinworms	Variable, may be as long as 3-6 weeks	Perianal itching	No		No	Treatment is recommended. Teach importance of handwashing
Poliomyelitis (polio)	3-21 days	Fever, headache, stomachache, stiff neck, usually with some vomiting. Often followed by paralysis	Yes	See Footnote 2(A-B)	Yes	Vaccine available. Report cases immediately to local health department and call the Texas Immunization Hot Line 1-800-252-9152
Ringworm of the Body	4-10 days	Slowly spreading, flat, scaly, ring-shaped spots on skin. The margins may be reddish and slightly raised	No		No	Treatment is recommended. Keep lesions covered while in school
Ringworm of the Scalp	10-21 days	Slowly spreading, balding patches on scalp with broken off hairs	Yes	When treatment has begun	No	Teach importance of not sharing combs, hats, and coats
Rubella (German measles)	14-21 days	Cold-like symptoms, swollen tender glands at back of neck. Changeable pink rash on face and chest	Yes	After 7 days from rash onset. In an outbreak unimmunized children should be excluded for at least 3 weeks after last rash onset occurs	Yes	Vaccine available. Report suspected cases immediately to local health department and call the Texas Immunization Hot Line 1-800-252-9152
Salmonellosis	1-3 days	Sudden onset of fever, abdominal pain, diarrhea, sometimes vomiting	Yes	When diarrhea subsides	Yes	Teach importance of handwashing. Frequently a foodborne infection
Scabies	First infection: 1 month Repeat infection: 2-5 days	Small, raised, red bumps or blisters on skin with severe itching	Yes	When treatment has begun	No	Careful examination of close contacts required to identify early infection. Household members should be treated prophylactically
Shigellosis	1-7 days	Sudden onset of fever, vomiting, and diarrhea	Yes	When diarrhea subsides	Yes	Teach importance of handwashing. Can spread quickly in child care facilities
Streptococcal Sore Throat and Scarlet Fever	1-3 days	Fever, sore throat, often with enlarged, tender lymph nodes in neck. Scarlet fever producing strains of bacteria cause a fine, red rash that appears 1-3 days after onset of sore throat	Yes	After 24 hours from time antibiotic treatment was begun	No	Teach importance of covering mouth when coughing or sneezing
Tuberculosis, Pulmonary	4-12 weeks	Gradual onset, tiredness, loss of appetite, slight fever, failure to gain weight, cough	Yes	After antibiotic treatment has begun, AND a physician's certificate or health permit obtained	Yes	All classroom contacts should have TB skin tests. Antibiotic prophylaxis indicated for newly positive reactors

---

[1] The major criterion for exclusion from attendance is the probability of spread from person to person. A child may have a nonexcludable illness yet require care at home or in a hospital

[2] Children excluded from a school or child care facility for a communicable disease may be readmitted by any of the following methods

(A) A written certificate from a physician

(B) A permit issued by the local health authority

(C) Fulfilling criteria listed under "Readmission Criteria"

[3] A school or child care facility administrator may require a note from a parent or physician for readmission regardless of the reason for the absence

[4] Children should not be given aspirin for symptoms of any viral disease, confirmed or suspected, without consulting a physician

Texas Department of Health

Adopted by the Texas Department of Health pursuant to 25 TAC 97.6. Effective on September 1, 1987

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APPENDIX B
GUIDELINES TO DETERMINE APPROPRIATENESS OF MONITORING VISIT

The following guidelines should be used to determine the appropriateness of a monitoring visit.

1. The visit must be unannounced.
2. If no answer on first try, return later. If no answer on second try, select replacement home.
3. The caregiver (or substitute) and children in care must be present. The home must be in operation as a caregiving facility at the time of your visit.
4. Children and caregiver(s) must be in the home long enough to complete standard by standard evaluation.
5. The monitor must not be placed at risk.

Some examples where you would not monitor to help interpret these guidelines:

Unannounced:	Husband/others at home but caregiver and children not home.
No Children:	Children on field trip, children sick, caregiver on vacation/holiday, non-operating hours.
Length of Visit:	Field trip planned in 10 minutes, parents picking up children on arrival of monitor.
Risk to Monitor:	You may choose to terminate any visit at any time, should you feel a risk to your safety.

APPENDIX C
INSTRUCTIONS FOR CHOOSING HOMES TO VISIT FROM THE SAMPLING LIST

RATIONALE

The sampling procedure is devised to be consistent with the following goals:

a. The sample must be representative.

b. There should be no unnecessary intrusion in the caregiver's life.

c. There should be no unnecessary interference in the childcare setting.

d. Monitoring visits must be unannounced.

e. Monitoring must be efficient.

PROCEDURE

1. From sampling list provided by the state office, begin with the first name on that list and, in order, call each caregiver to determine current operating address.

2. When you have identified 60 eligible RFHs, this will be you WORKING SAMPLE LIST. The remaining portion of the state office list is now your RESERVE SAMPLE LIST.

3. Organize your WORKING SAMPLE LIST according to area (e.g., zip code) to reduce travel costs.

4. Visit homes on WORKING SAMPLE LIST. Carry with you your RESERVE SAMPLE LIST.

5. If home is operating (see GUIDELINES TO DETERMINE APPROPRIATENESS OF MONITORING VISITS) complete standard by standard evaluation.

6. If home is not operating refer to your RESERVE SAMPLE LIST. Choose the next home on the list with the same zip code and attempt to visit.

7. If replacement home is not operating, choose the next home on the list with the same zip code and attempt to visit.

8. Continue replacement strategy (#'s 6 and 7 above) until a home is visited or until no more RFHs are found on the RESERVE SAMPLE LIST with the appropriate zip code.

9. If no appropriate replacement home can be found for that zip code, call Paul Grubb (450-3736) for further instructions.

10. If you complete the 60 visits before a new sample list is provided by the state office, repeat this procedure creating a new working list from the reserve sample list. This new working sample list should only be as large as what you expect to have time to complete. For example, if you think you can complete 12 more visits before the next quarter list, create a working sample list of 12.

APPENDIX D
RESEARCH INSTRUMENTS

Texas Department
of Human Services

PILOT

Draft
Form 2917
June 1990

REGISTERED HOME COMPLIANCE RECORD

SECTION A – IDENTIFYING INFORMATION

Registrant's Name	Region	Facility No.
Address (Street, City, Zip)		Telephone No.
Status ☐ Applicant ☐ Registered	Date	Waiver/Variance or Conditions in effect	Date last fee paid
Type of Evaluation ☐ Inspection ☐ Follow-up ☐ Complaint Investigation ☐ Consultation ☐ Other ______		
Date of Evaluation	Time of Arrival ☐ Ann. ☐ Unann.	Licensing Representative	Telephone No.

SECTION B – NOTICES

☐ COMPLAINT INVESTIGATION: The purpose of this visit is to investigate a complaint. You have been informed of the nature of the complaint. If the results of the investigation are not included on this form, you will be informed by letter or supplemental form.

☐ DUE NOTICE: If you fail to comply within the time limits noted or if you repeat the noncompliances indicated on the attached page(s), your registration may be revoked, or your application may be denied without further opportunity to correct the noncompliance(s). YOU MUST COMPLY WITH THE STANDARDS AND THE LAW AT ALL TIMES.

If you disagree with the actions or decisions of licensing staff, you may request an administrative review by contacting:

Name	Title
Address	Telephone No. (inc. A/C)

SECTION C – CHILDREN AND ADULTS PRESENT

Name	Age	Name	Age

Receipt of this RFH Compliance Record of ____ page(s) is acknowledged.

Signature – Person in Charge   Date   Signature – Licensing Representative   Date

Signed By:
☐ Registrant ☐ Other Person in Charge

Time of Departure

DHS USE ONLY

ACCLAIM

____Acclaim entry when visit made or initiated

acility	Date

Form 2917
Page 2

PILOT

ECTION —STANDARD EVALUATION

	Compliance	Non-comp.	N/A	Not Eval.
FH Meets Legal Definition (HRC 42.002(9))	☐	☐	☐	☐

000 THE CAREGIVER AND FAMILY

100 Caregiver Qualifications

	Compliance	Non-comp.	N/A	Not Eval.
1. Caregiver is age 21	☐	☐	☐	☐
If under 21, meets exceptions	☐	☐	☐	☐
2. Orientation Training	☐	☐	☐	☐
3. High School Diploma or GED	☐	☐	☐	☐
4. Registration Certificate displayed in prominent place	☐	☐	☐	☐
5. Current CPR certificate	☐	☐	☐	☐
Current first aid certificate	☐	☐	☐	☐
6. 20 clock hours training	☐	☐	☐	☐
7. Substitute Caregiver age 18	☐	☐	☐	☐

1200 People in the Home

	Compliance	Non-comp.	N/A	Not Eval.
1. No persons in the home whose behavior endangers children	☐	☐	☐	☐
2. When children are in care no one present who has been indicted of offenses covered in the standard (Appendix VIII)	☐	☐	☐	☐
3. When children are in care no one present who has been indicted or for whom D.A. accepted criminal complaint (offense list)	☐	☐	☐	☐
4. Criminal History Form for Substitute and adult residents	☐	☐	☐	☐
5. Record of negative TB exam for persons over 14 yrs	☐	☐	☐	☐
6. No smoking in home during hours of operation	☐	☐	☐	☐

2000 THE CHILDREN IN CARE

	Compliance	Non-comp.	N/A	Not Eval.
2100 Number of Children	☐	☐	☐	☐
2200 Admission Requirements	☐	☐	☐	☐
1. Current immunization & TB test (See Appendix I)	☐	☐	☐	☐
Parents' Telephone No's.	☐	☐	☐	☐
Emergency medical authorization	☐	☐	☐	☐
2. Receipts for Parent Guide	☐	☐	☐	☐
3. No racial discrimination	☐	☐	☐	☐
4. No child in care on 24 hrs. basis longer than 30 days at one time or no more than 45 days per year	☐	☐	☐	☐

3000 HEALTH AND SAFETY

3100 Fire, Sanitation, and Safety

	Compliance	Non-comp.	N/A	Not Eval.
1. Home meets requirements in Appendix II, III, IV, Fire Prevention, Sanitation, and Safety	☐	☐	☐	☐
2. Children protected from unsupervised access to any body of water on or near the premise (Appendix V)	☐	☐	☐	☐
3. Seat belts appropriate to child's age and size (Appendix VI)	☐	☐	☐	☐
4. Emergency forms and first aid supplies when children when away from home	☐	☐	☐	☐

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Facility	Date

Form 2917
Page 3

PILOT

	Compliance	Non comp.	N/A	Not Eval.
0 Nutrition Nutritious, adequate meals and snacks .... (Appendix VII)	☐	☐	☐	☐
0 Telephone				
. Working Telephone	☐	☐	☐	☐
. Posted telephone numbers near phone .... Ambulance or EMS Police or Sheriff Fire Poison Control DHS Office Each child's parents/or designee contact Own address & telephone Child abuse hot line	☐	☐	☐	☐
0 Accidents and Illnesses				
. Adult certified in CPR in home and available at all times	☐	☐	☐	☐
. First Aid Supplies/Guide available in a designated location (out of children's reach .... Multi size bandages Gauze Pads Tweezers Cotton Balls Hydrogen peroxide Syrup of Ipecac Thermometer	☐	☐	☐	☐
Written medication permission and Instructions	☐	☐	☐	☐
. Parents notified of sick/injured child at once and emergency attention attained, if serious	☐	☐	☐	☐

4000 CHILD CARE IN THE RFH

	Compliance	Non comp.	N/A	Not Eval.
4100 Supervision ...				
1. At all times by adult able to care for them	☐	☐	☐	☐
2. Caregiver aware of children at all times and able to assist or redirect activities	☐	☐	☐	☐
Supervision appropriate for age differences and abilities layout of house and play area neighborhood				
4200 Abuse or Neglect of Children				
1. No abuse/neglect in RFH	☐	☐	☐	☐
2. Suspected Abuse reported	☐	☐	☐	☐
3. Sign on reporting abuse posted	☐	☐	☐	☐
4300 Activities				
1. Developmentally Appropriate, regular indoor and outdoor activities .... Active and Quiet Sufficient toys and equipment available	☐	☐	☐	☐
2. Infants allowed activities outside cribs	☐	☐	☐	☐
4400 Discipline				
Discipline appropriate .... No harsh, cruel, or unusual punishment No shaking or hitting No spanking of children under 5 years old Spanking of children 5 years old and older only with signed parent permission, only open hand on child's buttocks	☐	☐	☐	☐

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Texas Department of
Human Services

PILOT

Research Form 1
Project CHERISH

Caregiver Name

Address

Facility #

Date of Evluation/Consultation

Monitor Name

Survey for Project Staff

Following a visit to a registered provider, please record the following information. Return one copy to the Research Specialist and file one copy in the record. Attach Form 2917 and Consultation Request.

GENERAL PERCEPTIONS

What are your general perceptions about the care provided in this home?

AREAS NOT ADDRESSED BY STANDARDS

Did you observe hazardous child care practices which were not addressed by standards? **Describe**

Did you observe **hazards in the home** that placed the children in danger which were not addressed by standards? **Describe**

PILOT

NONCOMPLIANCES/CORRECTIONS

In your opinion, did the provider understand how the home was not meeting standards? Yes ___ No ___ NA ___

Was the provider able to identify possible solutions/corrections? Yes ___ No ___

What is your confidence level in provider follow-through to meet the standards found in non-compliance?
Most Likely ___ Unknown/Unsure ___

What gives you this opinion?

Please identify the standard(s) and give an explanation of how the determination for correction date was established.

If follow-up on non-compliance is necessary, please indicate your recommendation for how the follow-up should be conducted. If a visit is necessary, do you recommend that a licensing representative conduct the visit?

CONSULTATION

Was consultation requested by the provider? Yes ___ No ___ NA ___

In what areas? ___

PILOT

Other areas where consultation could be helpful, but not requested by provider or did you strongly suggest it was needed?

OTHER COMMENTS

Project Staff — Date

PILOT

Standards Survey Questions for Caregiver

Instructions for Project CHERISH Monitor: Please take a few minutes at the end of each monitoring visit to obtain the caregiver's opinion of standards. Record her response to the following questions.

1. Which standards do you think are critical to the health and safety of children in family home care?

____

____

____

____

2. Do you think that any of the standards will be difficult for you to meet? (Help the caregiver to identify the standards and to consider factors such as cost, availability, appropriateness for home child care, etc.)

____

____

____

____

3. Are there areas of risk to children in family homes that are not currently addressed by the standards?

____

____

____

____

Attach this survey to the form 2917 which is sent to the Project Research Specialist and file a copy in the facility record.

Project CHERISH Caregiver Survey

PILOT

Please take a few minutes to give us your opinions about the inspection visit with our staff. Your comments will be very valuable to us as we plan visits to the homes of other caregivers. Please return this information in the envelope addressed to our central headquarters office in Austin.

1. Was the Project Monitor courteous? Yes No

   Was proper identification presented? Yes No

2. Was the Project Monitor helpful to you in understanding the standards? Yes No

3. Did the Project Monitor appear to be knowledgeable about standards? Yes No

   Was the Project Monitor organized and prepared for the visit? Yes No

   Did the inspection visit help you to better understand the standards and how to meet them? Yes No Comments? ______

Do you have other comments about the courtesy, helpfulness, and competency of the Monitor?

______

______

______

4. What useful information did you receive from the monitoring visit?

______

______

______

5. Please give us any other general comments about the inspection visit.

______

______

______

6. In what areas of child care giving or operating a family home would you like training and other assistance?

______

______

______

Thank you for having us in your home and for completing this form. Your responses are very important to us.

Name (optional) ______ Project Monitor ______

Address ______

PROJECT CHERISH TRACKING SHEET

PAGE ________

Case referred (Y/N)						
Consultation (Y/N)						
Date Follow-up Complete						
Date ACCLAIM						
Packet to Austin (✓)						
Follow-up required (Y/N)						
MAPPER deletion (✓)						
Details						
Evaluation status						
Evaluation date						
Date of Operating Call						
# of complaints past year						
Active complaint (Y/N)						
Facility Number						
Caregiver Name Address						

EVALUATION CODES

N = No answer
S = Status change

M = Moved
R = Refusal

D = Danger to monitor
P = Complaint pending (case by case)
Z = S X S Completed

C = No children
O = Other
[illegible]

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Texas Department
Of Human Services

Form 29
Aug 19

REGISTERED HOME COMPLIANCE RECORD

SECTION A - IDENTIFYING INFORMATION

Registrant's Name	Region	Facility No.
Address (Street, City, Zip)		(Area Code) Telephone No.
Status Date ☐ Applicant ☐ Registered	Waiver/Variance or Conditions in effect	

Type of Evaluation
☐ Inspection ☐ Follow-up ☐ Complaint Investigation ☐ Consultation ☐ Other ____________

Date of Evaluation	Time of Arrival	☐ Ann. ☐ Unann.

Licensing Representative

Name	Telephone No. (inc. A/C)
Address	

SECTION B - NOTICES

☐ COMPLAINT INVESTIGATION: The purpose of this visit is to investigate a complaint. You have been informed of the nature of t complaint. If the results of the investigation are not included on this form, you will be informed by letter or supplemental for

☐ DUE NOTICE: If you fail to comply within the time limits noted or if you repeat the noncompliance indicated on the attached page(s), your registration may be revoked or your application may be denied without further opportunity to correct the noncompliance(s). YOU MUST COMPLY WITH THE STANDARDS AND THE LAW AT ALL TIMES.

If you disagree with the actions or decisions of licensing staff, you may request an administrative review by contacting:

Name	Title
Address	Telephone No. (inc A/C)

Receipt of this RFH Compliance Record of ___ page(s) is acknowledged.

Signature - Person in Charge
Date
Signature - Licensing Representative
Date

Signed by
☐ Registrant ☐ Other Person in Charge

Time of Departure

Date of ACCLAIM entry

of Human Services

Form 291
Aug 199

Caregivers Name ______________________

SECTION C - PEOPLE PRESENT

CHILDREN PRESENT IN CARE

Child's Name	Birthdate	Age	Sex	In School	Records Shots	Records Test	Emergency Med.Auth.	Par. Guide Rept	Par. Tel.No.	Discipline Permission

No more than 6 total		School Age	No more than 12 Total
Infants	Preschool		

ADULTS IN HOME - (14 years and over)

	Identified in Record	Role/ Relationship	Sex	Birthdate	CPR (date)	Criminal History Check	TB Test	Present Today
A.								
B.	Not in Record Get 2971 and TX. DL#							

Caregiver's Name ______________________

Date ______________________

MINIMUM STANDARDS EVALUATION CHECKLIST

RFH Meets Legal Definition
(HRC 42.002(0))

1000 THE CAREGIVER AND FAMILY

TECHNICAL CONSULTATION			Compliance				Determined by	
Provided during visit	Requested for later time		Compliance	Non-comp.	N/A	Not Eval.	Direct Observation	Discussion w/Caregiver
		1100 Caregiver Qualifications (Page 1 of Stds.)						
____	____	1. Caregiver is age 21	☐	☐	☐	☐	____	____
		If under 21, meets exemptions.......................... (Circle appropriate exemption) a. child develop. associate credential (CDA) b. AA or AS in child care c. College certificate in child care d. recognized accreditation or credential e. recognized course of study + 9 mths experience f. "grandfather" exemption	☐	☐	☐	☐	____	____
____	____	2. Orientation Training.................................... (For those registered before July 2, 1990 check N/A)	☐	☐	☐	☐	____	____
____	____	3. High School Diploma or GED............................ (For those registered before July 2, 1990 check N/A)	☐	☐	☐	☐	____	____
____	____	4. Registration Certificate displayed in prominent place.	☐	☐	☐	☐	____	____
____	____	5. a. Current first aid certificate......................	☐	☐	☐	☐	____	____
____	____	b. Current CPR certificate............................	☐	☐	☐	☐	____	____
____	____	6. 20 clock hours training................................ (Not evaluated until July 1, 1991) Cumulative hours since Feb. 1990________	☐	☐	☐	☐	____	____
____	____	7. a. Substitute Caregiver age 18	☐	☐	☐	☐		
		b. 14-17 year old helper not left alone with children..............................	☐	☐	☐	☐	____	____
		1200 People in the Home (Page 2 of Stds.)						
____	____	1. No persons in the home whose behavior endangers children................................	☐	☐	☐	☐	____	____
____	____	2. When children are in care no one present who has been convicted of offenses covered in the standard (Appendix VIII)..	☐	☐	☐	☐	____	____
____	____	3. When children are in care no one present who has been indicted or for whom D.A. accepted criminal complaint (offense list, Appendix VIII)................................	☐	☐	☐	☐	____	____

Caregiver's Name ______________________________
Date ______________________________

MINIMUM STANDARDS EVALUATION CHECKLIST

ECHNICAL CONSULTATION							Determined by	
Provided during visit	Requested for later time		Compliance	Non-comp.	N/A	Not Eval.	Direct Observation	Discussion wit Caregiver
		4. a. Criminal History Form(s) for Substitute and adult residents.. (Number missing ________)						
		b. Adults residing in home.............................. (Indicate number__________)						
		5. Record of negative TB exam for persons over 14 yrs.... (If required)						
		6. No smoking in home during hours of operation.......... (Check here if no one in RFH smokes regularly _____)						
		2000 THE CHILDREN IN CARE						
		2100 Number of Children (Page 3 of Stds.)						
		2200 Admission Requirements (Page 4 of Stds.)						
		1a. Current immunization						
		b. Current TB test.......................................						
		c. Parent's telephone numbers............................						
		d. Emergency medical authorization.......................						
		Receipts for Parent Guide.................................. (Indicate number of receipts missing _______)						
		3. No racial discrimination...............................						
		4. No child in care on 24 hr. basis longer than 30 days at one time or more than 45 days per year						
		3000 HEALTH AND SAFETY						
		3100 Fire, Sanitation, and Safety (Page 5 of Stds.)						
		3100.1 Home indoors & outdoors, free of hazards & safe & healthy (Specify ______________________________ ______________________________)						
		3100.A Fire (from Appendix II) (Page 11 of Stds.)						
		a. Plans in place for fires/emergencies..................						
		b. Practice emergency plans every 6 months................						
		c. Elec. wiring, fuses, circuit breakers, appliance cords, & light fixtures in safe condition....................						

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aregiver's Name ______________________
ate ______________________

MINIMUM STANDARDS EVALUATION CHECKLIST

ECHNICAL CONSULTATION							Determined by	
Provided during visit	Requested for later time		Compliance	Non-comp.	N/A	Not Eval.	Direct Observation	Discussion wit Caregiver
		d. Central heating units inspected as recommended........						
		e. 1 - fireplace spark screen/guard...................... (check here if no fireplace ______)						
		2 - Floor/Wall furnace grates/space heaters have screen or guard......................................						
		3 - No open flame space heater						
		4 - Space heaters enclosed						
		5 - Space heater seal of approval displayed...........						
		f. Liquid/gas fuel heater properly vented................						
		g. 1 - Smoke detectors operating......................... (Number of smoke detectors ______)						
		h. 1 - Fire extinguisher in kitchen...................... (Type, if not 40BC _______; check here if approved in writing_______)						
		2 - Fire extinguisher checked as required.............						
		3 - Adult present who can operate fire extinguisher...						
		i. Two unblocked exits to outside of home................ (_____ door(s), _____ window(s))						
		3100.1B Sanitation (Appendix III) (Page 13 of Stds.)						
		a. Public water supply _____ or approved private well___ (Check one)						
		b. Public sewage system ___ or approved private sewage system _____ (Check one)						
		c. Running water in home						
		d. 1 - One flush toilet in home (Indicate total number of toilets ____)						
		2 - One lavatory inside the home (Indicate total number of lavatories ____)						
		e. 1 - Caregiver washes hands with soap & running water..						
		a. after using toilet............................						
		b. before eating.................................						
		c. before and after changing diaper..............						
		d. before and after assisting child with toileting						
		e. before and after feeding child................						

Caregiver's Name ______________________________
Date ______________________________

MINIMUM STANDARDS EVALUATION CHECKLIST

TECHNICAL CONSULTATION Provided during visit	TECHNICAL CONSULTATION Requested for later time		Compliance	Non-comp.	N/A	Not Eval.	Determined by Direct Observation	Determined by Discussion with Caregiver
____	____	f. before and after handling food................					____	____
____	____	g. before and after caring for child with symptoms of communicable disease.....................					____	____
		e. 2 - Child(ren) wash hands with soap & running water:						
____	____	a. after using toilet............................					____	____
____	____	b. before eating.................................					____	____
		3100.1C Safety (Appendix IV) (Page 15 of Stds.)						
		a. Children cannot reach/gain access to:						
____	____	1. cleaning supplies................................					____	____
____	____	2. bug spray..					____	____
____	____	3. medicines..					____	____
____	____	4. Other hazardous materials......................... List ______________________________ ______________________________					____	____
____	____	b. 1. Animal vaccination records available as required..					____	____

PETS	VACCINATION REQUIRED (Y/N)	DOCUMENTATION AVAILABLE (Y/N)

____	____	2. No stray animals.................................					____	____
____	____	3. Children kept away from dangerous animals.........					____	____
____	____	c. DHS notified of serious occurrence as required......... (Indicate date and type of occurrence(s) for past year ______________________________ ______________________________ ______________________________					____	____
____	____	d. Disallowed toys not present........................... (Circle area(s) of non-compliance)					____	____

1. exploding toys
2. shooting toys
3. toys containing poisonous materials

Caregiver's Name ______________________
Date ______________________

MINIMUM STANDARDS EVALUATION CHECKLIST

TECHNICAL CONSULTATION							Determined by	
Provided during visit	Requested for later time		Compliance	Non-comp.	N/A	Not Eval.	Direct Observation	Discussion with Caregiver
____	____	e. Lightweight, relatively pliable swing seat .... (Check here if no swings at residence ______)	☐	☐	☐	☐	____	____
		f. Appropriate fall zone ensured for:						
____	____	1. climbing structure.................................. (Check here if no structure at residence____)	☐	☐	☐	☐	____	____
____	____	2. slide.. (Check here if no slide at residence ____)	☐	☐	☐	☐	____	____
____	____	3. swing set.. (Check here if glider present _____)	☐	☐	☐	☐	____	____
____	____	4. merry go round or other revolving device (Check here if no revolving device at residence__)	☐	☐	☐	☐	____	____
____	____	g. No entrapping equipment.............................	☐	☐	☐	☐	____	____
____	____	h. No pinch, crush or shear points......................	☐	☐	☐	☐	____	____

3100.2 Water Activities (Appendix V) (Page 17 of Stds.)
(Indicate appropriate condition)

____ 1. No body of water on or near premises

____ 2. Water near premises (Circle as appropriate)

Swimming pool (2ft.+) Pond Other __________

Wading pool Creek __________

____ 3. Water on premises (Circle as appropriate)

Swimming pool Pond Other __________

Wading pool Creek __________

		2a. Wading Pool (if appropriate)						
____	____	1. drained after each use...........................	☐	☐	☐	☐	____	____
____	____	2. cleaned after each use...........................	☐	☐	☐	☐	____	____
____	____	3. stored when not in use...........................	☐	☐	☐	☐	____	____
____	____	b. No unsupervised access to swimming pool/other water	☐	☐	☐	☐	____	____
____	____	c. No play activities near unfenced pool in apartment complex.....................................	☐	☐	☐	☐	____	____

Caregiver's Name ______________________________

Date ______________________________

MINIMUM STANDARDS EVALUATION CHECKLIST

TECHNICAL CONSULTATION							Determined by	
Provided during visit	Requested for later time		Compliance	Non-comp.	N/A	Not Eval.	Direct Observation	Discussion wit Caregiver
________	________	d. Appropriate number of adults present for wading pool (Indicate number of adult caregivers usually present ________)	☐	☐	☐	☐	________	________
		e. Appropriate adults present for swimming pool:						
________	________	1. Adult currently certified in water safety........ (Circle: type of certification) a. Life saving b. water safety c. life guard d. other: specify _______	☐	☐	☐	☐	________	________
________	________	2. Adult/child ratio met..........................	☐	☐	☐	☐	________	________
________	________	f. Life saving device present.......................... (Indicate number of devices ____)	☐	☐	☐	☐	________	________
________	________	g. Pool chemicals stored out of reach.................	☐	☐	☐	☐	________	________
		3100.3 Transportation (Appendix VI) (Page 19 of Stds.)						
________	________	a. Children under 2 in infant carrier or child seat.....	☐	☐	☐	☐	________	________
________	________	b. Over 2 in child seat or seat belt; one person per belt	☐	☐	☐	☐	________	________
________	________	c. Shoulder harness not across face or neck.............	☐	☐	☐	☐	________	________
________	________	d. Restraints properly anchored and used correctly......	☐	☐	☐	☐	________	________
________	________	e. Children do not ride in open back of pick-up truck...	☐	☐	☐	☐	________	________
		3100.4 Forms and Supplies (Page 5 of Stds.)						
________	________	a. Emergency forms when children away from home........	☐	☐	☐	☐	________	________
________	________	b. Emergency first aid supplies when children away from home...	☐	☐	☐	☐	________	________
		3200 Nutrition (Appendix VII) (Page 5 of Stds.)						
________	________	1. Nutritious, adequate meals and snacks.................	☐	☐	☐	☐	________	________
		Check usual meals provided children daily: Breakfast _____ Morning Snack _____ Lunch _____ Afternoon Snack _____ Dinner _____						

Caregiver's Name ______________________
Date ______________________

MINIMUM STANDARDS EVALUATION CHECKLIST

ECHNICAL CONSULTATION							Determined by	
Provided during visit	Requested for later time		Compliance	Non-comp.	N/A	Not Eval.	Direct Observation	Discussion wit Caregiver
		3300 Telephone (Page 5 of Stds.)						
____	____	1. Working telephone....................................					____	____
____	____	2. Posted telephone numbers near phone.................... (Circle those missing)					____	____
		a. Ambulance or EMS						
		b. Police or Sheriff						
		c. Fire						
		d. Poison Control						
		e. DHS Office						
		f. Each child's parents/designated contact						
		g. Own address and telephone number						
		h. Child abuse hot line						
		3400 Accidents and Illnesses (Page 6 of Stds.)						
____	____	1. Adult certified in CPR in home and available at all times when caregiver not present..................					____	____
____	____	2a. First aid supplies available........................... (Circle those items missing)					____	____
		a. Multi size bandages						
		b. Gauze Pads						
		c. Tweezers						
		d. Cotton Balls						
		e. Hydrogen Peroxide						
		f. Syrup of Ipecac						
		g. Thermometer						
____	____	b. First aid supplies in designated location.............					____	____
____	____	c. First aid supplies out of children's reach............					____	____
____	____	d. Guide to first aid accessible.........................					____	____
____	____	3. Written medication permission and instructions........					____	____
____	____	4a. Parents notified of sick/injured child at once........					____	____
____	____	b. Emergency attention obtained for serious sickness/ injury of child..					____	____

Caregiver's Name ____________________
Date ____________________

Page

MINIMUM STANDARDS EVALUATION CHECKLIST

TECHNICAL CONSULTATION							Determined by	
Provided during visit	Requested for later time	4000 CHILD CARE IN THE RFH	Compliance	Non-comp.	N/A	Not Eval.	Direct Observation	Discussion with Caregiver
		4100 Supervision (Page 7 of Stds.)						
		1. At all times by adult able to care for them...........						
		2a. Caregiver aware of children at all times..............						
		b. Caregiver able to assist or redirect activities.......						
		c. Supervision appropriate.................................. (Circle inappropriate supervision area) 1. age 2. differences and abilities 3. layout of house and play area 4. neighborhood						
		4200 Abuse or Neglect of Children (Page 7 of Stds.)						
		1. No abuse/neglect in RFH................................						
		2. Suspected abuse reported...............................						
		3. Sign on reporting abuse posted.........................						
		4300 Activities (Page 7 of Stds.)						
		1a. Developmentally appropriate............................						
		b. Regular indoor and outdoor activities..................						
		c. Both active and quiet play included....................						
		d. Sufficient developmentally appropriate toys and equipment available....................................						
		2. Infants allowed activities outside cribs...............						
		4400 Discipline (Page 7 of Stds.)						
		1. Discipline appropriate................................. (Circle area of non-compliance) a. No harsh, cruel, or unusual punishment b. No shaking or hitting c. No spanking of children under 5 yrs of age						

Caregiver's Name ______________________________
Date ______________________________

MINIMUM STANDARDS EVALUATION CHECKLIST

TECHNICAL CONSULTATION							Determined by	
Provided during visit	Requested for later time		Compliance	Non-comp.	N/A	Not Eval.	Direct Observation	Discussion with Caregiver
		2. Spanking policy followed (Check here if spanking is not used as discipline for children 5 yrs old and older ____)	☐	☐	☐	☐		
____	____	a. Signed permission..................................	☐	☐	☐	☐	____	____
____	____	b. Open hand..	☐	☐	☐	☐	____	____
____	____	c. Limited to buttocks................................	☐	☐	☐	☐	____	____

STANDARDS SURVEY QUESTIONS FOR CAREGIVER

Caregiver Name:________________________

Facility Number________________

Instructions: Please take a few minutes at the end of each monitoring visit to obtain the caregiver's opinion of standards. Record her response to the following questions.

1. Do the RFH standards promote the health and safety of children? YES NO

2. What difficulties are there for you in meeting the minimum standards?
(Pair appropriate number(s) with standard(s)

1. locate qualified substitutes
2. cost to obtain necessary materials
3. dependence on parents to supply materials
4. cost to maintain necessary materials
5. cost of training
6. finding time to attend training
7. cost of physical renovation of home or vehicle
8. lack of understanding
9. disagree with philosophy
10. knowledge of business practices
11. Other ______________________________

____ a. 1100 Training
____ b. 1200 People in Home
____ c. 2100 Number of children in care
____ d. 2200 Admission requirements
____ e. 3100 Fire prevention
____ f. 3100 Sanitation
____ g. 3100 Safety
____ h. 3200 Nutrition
____ i. 3300 Telephone
____ j. 3400 Accidents/Illness
____ k. 4100 Supervision
____ l. 4200 Abuse/neglect of children
____ m. 4300 Activities
____ n. 4400 Discipline

3. Please explain area(s) of disagreement/difficulties with the standards, if any.

____

____

____

4. Are you on a food assistance program? YES NO

5. Do you belong to a professional child care organization? YES NO

6. Do you belong to a childcare referral network? YES NO

7. Are there areas of risk to children in family homes that are not currently addressed by the standards?

NO YES (specifics): ____________________________________

____

8. Attended minimum standards training? (Circle NA if registered after July 1, 1990)

YES NO NA

If NO why not? (check all that apply)

____ a. inconvenient time(s)
____ b. cost
____ c. no interest
____ d. did not know
____ e. not enough notice
____ f. other ____________________

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9. Last year of school completed. (Check one)

____ a. less than 6th grade
____ b. 7th to 9th grade
____ c. 10th to 11th grade
____ d. high school diploma or GED
____ e. 1 year college
____ f. 2 year college
____ g. 3 year college
____ h. undergraduate degree
____ i. graduate training
____ j. Masters degree or above

10. Indicate previous training. (Check all that apply)

____ a. child development associate credential
____ b. associate of arts in child care
____ c. a community of junior college certificate in child care

11. Hours of child care training in the past 2 years.

__________ hours

12. Areas of previous training in child care. (Check all that apply)

____ a. child development
____ b. discipline and guidance
____ c. nutrition
____ d. age and developmentally appropriate activities
____ e. sanitation
____ f. health
____ g. safety
____ h. business management
____ i. risk reduction/risk management
____ j. communication
____ k. parent involvement
____ l. community resources

13. Where training obtained. (check all that apply)

____ a. junior college
____ b. university/4 yr college
____ c. county extension offices
____ d. Child care associations
____ e. Technical/Vocational School
____ f. Consultants
____ g. Food program sponsor
____ h. Other. Specify __________

14. In what areas of child care giving or operating a family home would you like training or other assistance from Texas Department of Human Services?

____
____
____

Caregiver Name ____________________

Texas Department of Human Services
Survey for Project Staff

Caregiver name ______________________________
Address ______________________________
Facility number ______________________________

Monitor name ______________________________
Date ______________________________
Percent of Time Observing ____ % Consulting ____ %
Paperwork ____ %

Directions: Please record your impressions as soon as possible following your visit to the RFH. Attach one copy to Form 2917 and return it to the Research Specialist. File one copy in the record.

GENERAL PERCEPTIONS	Poor	Fair	Good	Very Good	Excellent	Not Applicable
1. Overall quality of care for children	1	2	3	4	5	N
2. Overall safety of inside RFH facility	1	2	3	4	5	N
3. Overall safety of immediate outside area	1	2	3	4	5	N
4. Overall cleanliness of RFH	1	2	3	4	5	N
PERCEPTIONS OF CAREGIVERS						
5. Understanding of standards	1	2	3	4	5	N
6. Willingness to comply with standards	1	2	3	4	5	N
7. Cooperation during visit	1	2	3	4	5	N
8. Chance that provider will correct noncompliance(s)	1	2	3	4	5	N
9. Interest in further training	1	2	3	4	5	N
10. Professional bearing	1	2	3	4	5	N
11. Effective childcare practices	1	2	3	4	5	N
12. Degree of nurturing the children	1	2	3	4	5	N
PERCEPTIONS OF CHILDCARE PRACTICES						
13. Children's routine/activities	1	2	3	4	5	N
14. Equipment/materials	1	2	3	4	5	N
15. Inside physical environment	1	2	3	4	5	N
16. Outside physical environment	1	2	3	4	5	N
17. Crowdedness	1	2	3	4	5	N
18. Provider/child interaction	1	2	3	4	5	N
19. Provider/parent interaction	1	2	3	4	5	N
20. Handling outside interference	1	2	3	4	5	N
21. Record keeping/administrative	1	2	3	4	5	N
22. Other ____________________	1	2	3	4	5	N

FOLLOW-UP RECOMMENDATION

23. Follow up recommended? Yes _____ No _____ Not Applicable _____
24. If yes, what kind? Telephone _____ Visit _____ Mail _____
25. If yes, by whom? Self _____ License Rep _____ Other specify__________

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RFH ENVIRONMENT (Check one from each set)

26. TYPE

____ a. Apartment
____ b. Mobile Home
____ c. Single Family residence
____ d. Duplex or multiple family residence
____ e. Other Specify ____________________

27. AREA

____ a. Rural
____ b. Urban
____ c. Suburban

28. CLEANLINESS

____ Well kept neighborhood
____ Average neighborhood
____ Some deterioration in neighborhood
____ Poorly kept neighborhood

29. SAFETY

____ a. Very high risk for children
____ b. High risk for children
____ c. Moderate risk for children
____ d. Low risk for children

30. TRAFFIC

____ a. Borders heavy use street
____ b. Within 1 block of heavy use street
____ c. Within 2 blocks of heavy use street
____ d. More than 3 blocks away from heavy use street

31. Describe hazardous practices or environmental hazards observed but not specified in standards.

____
____
____
____
____

32. Describe any unique and/or innovative childcare practices observed that might be useful to other caregivers.

____
____
____

33. Describe any consultation/advise not directly associated with the standards that you feel could be helpful for this caregiver.

____
____
____

34. Suggestions for improvements for monitoring system.

____
____
____

Caregiver Name ______________________________

CAREGIVER SURVEY

Monitor's Name ____________________

PROJECT CHERISH REGISTERED FAMILY HOME VISITS

Region______ ______

This survey is designed to gather information that will help the Texas Department of Human Services in its commitment to provide quality service. Please take a few minutes to complete this questionnaire by circling the number that best reflects your thoughts. Your comments are very valuable to us as we plan visits to the homes of other caregivers.

	Especially	Very	Moderately	Not Very	Not	Not Applicable
1. How courteous was the project monitor?	1	2	3	4	5	N
2. How helpful was the project monitor?	1	2	3	4	5	N
3. How knowledgeable did the project monitor seem?	1	2	3	4	5	N
4. How useful was the information given to you?	1	2	3	4	5	N
5. How professional was the monitoring visit?	1	2	3	4	5	N
6. How agreeable was the monitoring visit?	1	2	3	4	5	N
7. How much do you think monitoring visits promote the health and safety of children?	1	2	3	4	5	N
8. How well do the minimum standards cover the critical areas of safety and health of children?	1	2	3	4	5	N
9. How necessary are the minimum standards for the safety and health of children?	1	2	3	4	5	N
10. How clear and understandable are the minimum standards?	1	2	3	4	5	N
11. How reasonable were the compliance dates?	1	2	3	4	5	N
12. How much say did you have in determining compliance dates?	1	2	3	4	5	N
13. How easy will it be for you to comply with the minimum standards?	1	2	3	4	5	N
14. How reasonable will the costs be for you to comply with the minimum standards?	1	2	3	4	5	N
15. Before the monitoring visit, how familiar were you with the new minimum standards?	1	2	3	4	5	N
16. Before the monitoring visit, did you receive a copy of the new minimum standards?			No	Yes		

Name: (Optional) ______________________ Phone: ______________________

Address: ____

APPENDIX E
PROJECT STAFF

This project was designed and carried out at the direction of Cris Ros-Dukler, Director of Licensing at the Texas Department of Human Services. Kathryn Kramer wrote the original grant request. Lynda Winstead, RFH program specialist, was responsible for implementing the project and coordinating field staff. Paul Grubb was responsible for the technical aspects of the study, including the design of research procedures and materials and the analysis and reporting of the data. Grace Neid, staff trainer, provided training for field monitors and supervisors. Technical consulting was provided by Judy Evans, Supervisor, in the Child Protective Services, Research and Evaluation section. Dorothy Turner and Marta Blumenthal translated forms into Spanish. Special thanks to Christine Rotolo for her clerical and organizational support and to Elizabeth Taylor and Heidi Reifel for their word processing support.

State Office Project Staff

Lynda Winstead, Program Specialist
Paul Grubb, Ph.D, Research Specialist
Grace Neid, Staff Trainer

Regional Day Care Project Staff

Region 01/02
Rebecca Conklin, Supervisor
Elizabeth Lynch, Monitor

Region 03
Judy Walker, Supervisor
Peter Olszewski, Monitor

Region 04
Walter Jones, Supervisor
Mary Beth Mims, Monitor

Region 05
Nancy Garrett, Supervisor
Charlene Warfield, Monitor
Paula Roberts, Monitor
Michelle Adams, Monitor

Region 06
Virginia Best, Supervisor
Jesse Vasquez, Monitor
Marilyn Wesson, Monitor

Region 07
Shelley Judd, Supervisor
Shelley Judd, Monitor
Marie Crowe, Monitor

Region 08
Mario Trejo, Supervisor
Rodolpho Caballero, Monitor

Region 09
Mario Trejo, Supervisor
Cynthia Smith, Monitor
Elaine Mittel, Monitor

Region 10/11
Connie Presley, Supervisor
Rosalie Millsap, Monitor
Joy Kiernan, Monitor
Naomi McCall, Monitor

Region 12
Judy Walker, Supervisor
Aza Lee Griffin, Monitor